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JANUARY 1973  
VOL. 69 NO. 1

# The Ohio State MEDICAL JOURNAL

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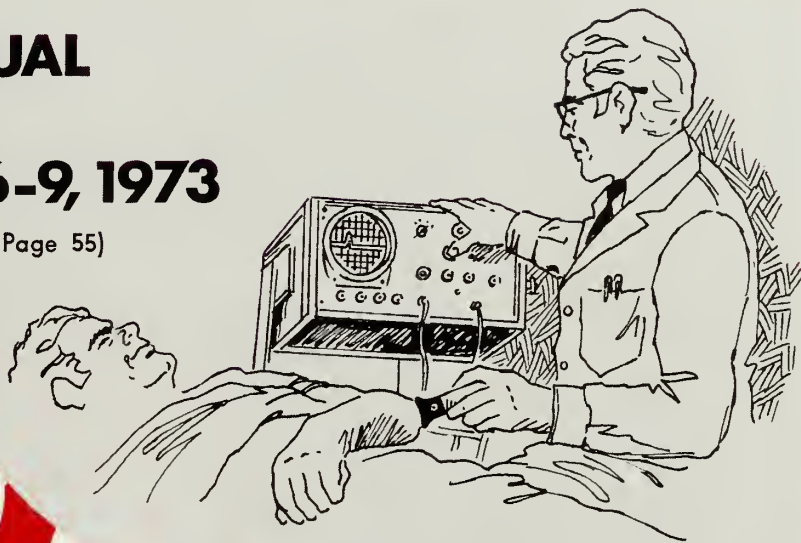
22 JAN 1973

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

## OSMA ANNUAL MEETING

May 6-9, 1973

(See Page 55)



# EDUCATION



EXCHANGE OFFICE  
FRANCIS A. CUNTYWAY  
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Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).

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Reglue







Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

Valium®  
(diazepam)

To help you manage excessive psychic tension

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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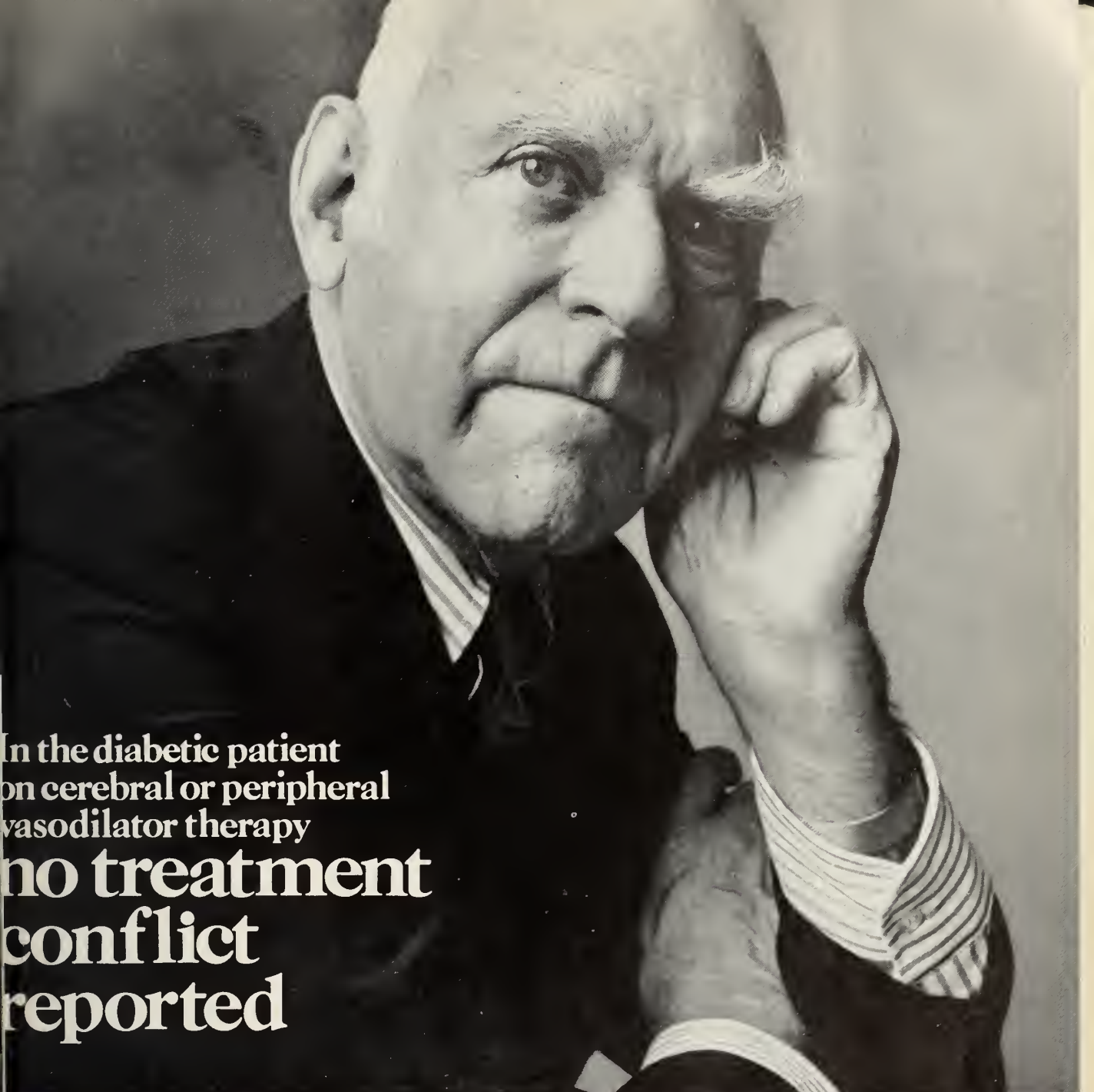
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In the diabetic patient  
on cerebral or peripheral  
vasodilator therapy  
no treatment  
conflict  
reported

# VASODILAN®

(ISOXSUPRINE HCl)  
the compatible vasodilator

- no interference with diabetic control . . . does not alter carbohydrate metabolism.<sup>1</sup>

- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.

There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**INDICATIONS:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**DOSAGE AND ADMINISTRATION:** 10 to 20 mg. three or four times daily.

**CONTRAINDICATIONS AND CAUTIONS:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**ADVERSE REACTIONS:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**SUPPLIED:**

Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose  
20 mg.—bottles of 100, 500 and Unit Dose

**REFERENCE:** 1. Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. 54:1021-1023 (July) 1961.

**Mead Johnson**  
LABORATORIES

**COMPOSITION:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

1972 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. 10372

# Community Joins Mahoning County Medical Society in Climax to Centennial Celebration

EVENTS RELATING to the centennial celebration of the Mahoning County Medical Society took the limelight in the Youngstown area for the week of October 29-November 4 and culminated in a gala Saturday evening program.

The Society sponsored "Salute to the American Arts" netted more than \$26,000 for the four established art groups in Youngstown, the Youngstown Symphony, Playhouse, Ballet Guild, and the Butler Institute of American Art. The month of November was given over to a display, "Medicine in Art," at the Butler Institute. This included the 45 original oil paintings of the Parke-Davis collection, depicting highlights in the history of medicine from ancient times. The artist, Henry Koerner and his wife were guests for the celebration. Local historical exhibits were also part of the celebration (see October issue of *The Journal*, page 912).

Dr. Henry Holden, Society president, reported that more than 1800 people attended the centennial celebration in the Powers Auditorium. The backing of the community was further indicated by the fact that Youngstown Mayor Jack C. Hunter proclaimed the period as "Mahoning County Medical Society Week."

The Mahoning County Medical Society was founded on November 13, 1872. In preparation for the celebration, a centennial committee was appointed last year. The committee consisted of the 29 living past presidents, the president, the president-elect, plus the president and president-elect of the Woman's Auxiliary. Dr. Jack Schreiber was named chairman with Dr. John J. McDonough as cochairman.

The committee sponsored a contest to design a special seal for use in connection with the cen-



Dr. Henry Holden, president of the Mahoning County Medical Society, displays the centennial program to two distinguished guests, Dr. William R. Schultz, center, President of the Ohio State Medical Association, and Dr. Maurice F. Lieber, OSMA Sixth District Councilor.





Dr. Jack Schreiber, right, centennial committee chairman, discusses program features with OSMA President William Schultz, and Dr. James H. Sammons, Baytown, Texas, member of the AMA Board of Trustees. On the left is Dr. John J. McDonough, cochairman of the centennial committee.

ennial activities. The winning design was submitted by Mrs. Henry Holden, wife of the president.

The *Bulletin* of the Society included historical articles throughout the year, and the November issue was a special historical number. Editor is Dr. John C. Malnick.

For 21 years, the Society has been exhibiting and sponsoring a combined health exhibit (allied professions and voluntary health agencies) at the Mahoning County Fair, better known as the Canfield Fair. (More was reported on this in the October issue article.)

Early in the year an appeal was made for each physician member of the Society to contribute \$100, or \$1 for each year of the Society's existence. More than \$20,000 was raised in this manner. Also an appeal was made to the public for donations, and tickets were sold to help raise the money contributed to the four art groups.

A new street is being constructed to give a better entrance to the emergency department and parking lot of the Youngstown Hospital's South Unit. City Council has been petitioned to name this street for Dr. Charles Dutton, Youngstown's first physician who entered practice there in 1801.

In serious gram-negative infections\*

# Simplified dosage guidelines

**Usual adult dosage - -I.M. and I.V.- - in patients with normal renal function**

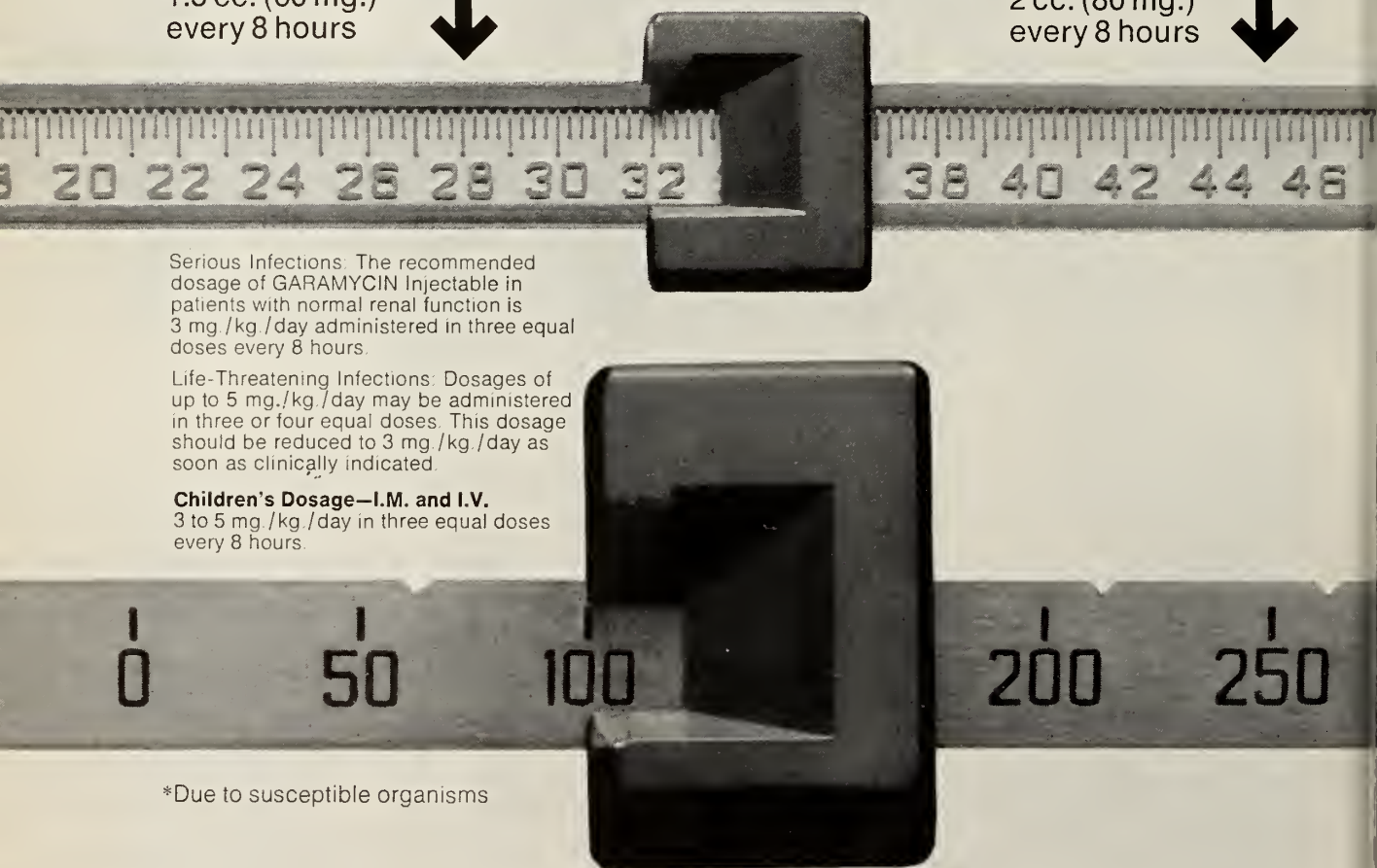
**132 lbs. or less**

1.5 cc. (60 mg.)  
every 8 hours



**Over 132 lbs.**

2 cc. (80 mg.)  
every 8 hours



**Serious Infections:** The recommended dosage of GARAMYCIN Injectable in patients with normal renal function is 3 mg./kg./day administered in three equal doses every 8 hours.

**Life-Threatening Infections:** Dosages of up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

**Children's Dosage—I.M. and I.V.**

3 to 5 mg./kg./day in three equal doses every 8 hours.

\*Due to susceptible organisms

**WARNING**

Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN,

creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or continuance of the drug.

In event of overdose or toxic reaction, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic or nephrotoxic drugs, particularly streptomycin, should be avoided.



# Garamycin<sup>®</sup>

## gentamicin sulfate

### injectable

**I.M./I.V.**
**40 mg. per cc.**

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

## Duration of therapy—I.M. and I.V.

The usual duration of treatment is 7 to 10 days. In difficult and complicated infections, a longer course of therapy may be necessary.

## Instructions for I.V. use

**Dilution**—A single dose is diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution should not exceed 1 mg./cc. (0.1%).

**Infusion time**—The solution is infused over a period of 1 to 2 hours.

**Premixing**—GARAMYCIN Injectable should not be physically premixed with other drugs but should be administered separately in accordance with the recommended route of administration and dosage schedule.

## In adults with impaired renal function

The single dose of GARAMYCIN Injectable given by patient weight remains the same; however, the interval between doses must be extended.

This interval may be approximated by multiplying the serum creatinine by eight as follows:

$$\text{Serum creatinine (mg./100 ml.)} \times 8 = \text{frequency of administration (in hours)}$$

This dosage schedule is not intended as a rigid recommendation, but is provided as a guide to dosage when the measurement of gentamicin serum levels is not feasible.

See Clinical Considerations section which follows...

neomycin, kanamycin, cephaloridine, gentamicin, polymyxin B, and polymyxin E (Bactin), should be avoided. The concurrent use of gentamicin with diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

**USE IN PREGNANCY** Safety for use in pregnancy has not been established.

**Garamycin® Injectable**  
brand of gentamicin sulfate U.S.P., injection, 40 mg./cc.  
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin  
For Parenteral Administration

**WARNING:** Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause toxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

**USAGE IN PREGNANCY** Safety for use in pregnancy has not been established.

**INDICATIONS** GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

*Pseudomonas aeruginosa*, *Proteus* species (indole-positive and indole-negative), *Escherichia coli* and *Klebsiella-Enterobacter-Serratia* species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

**CONTRAINDICATIONS** A history of hypersensitivity to gentamicin is a contraindication to its use.

**WARNINGS** See Warning Box.

**PRECAUTIONS** Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible

organisms. If this occurs, appropriate therapy is indicated.

#### ADVERSE REACTIONS

**Nephrotoxicity:** Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

**Neurotoxicity:** Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

**Note:** The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

**DOSAGE AND ADMINISTRATION** GARAMYCIN Injectable may be given intramuscularly or intravenously.

**For Intramuscular Administration:**

**PATIENTS WITH NORMAL RENAL FUNCTION\***

**Adults:** The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

\*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

**For Intravenous Administration:**

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

**HOW SUPPLIED** GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972  
AHFS Category 8:12.28

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

SLR-192

**Garamycin®**  
gentamicin  
sulfate  
**Injectable**  
**I.M./I.V.**

**40 mg. per cc.**

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin



## Sports Medicine Center Established at CWRU

The Rainbow Sports Medicine Center is the newly established unit at Rainbow Hospital. Affiliated with University Hospitals of Cleveland and Case Western Reserve University School of Medicine, Rainbow has a long history of interest in children's orthopaedic problems. Hence, sports medicine is a natural for its orthopaedic staff.

Treatment of adolescent sports injuries will be a major focus of the Center. Equally important functions will be research into sports equipment and ways to prevent sports injuries through proper exercises, taping and padding.

"Our chief thrust will be aiding high school athletes," said Dr. Robert Mack, newly appointed director of the Center. Dr. Mack is head of orthopaedic surgery at Cleveland Metropolitan General Hospital and assistant professor in orthopaedic surgery at CWRU Medical School.

An avid skier, Dr. Mack is one of four doctors—all of whom are associated with the new Center—who conducted experiments to test ski bindings. The results, published in the December *Journal of Safety Research*, show most bindings do not protect skiers adequately. The experiment won an award from the U.S. Ski Association and the American Academy of Orthopaedic Surgeons.

Dr. Mack is team physician for the Cleveland Barons and Crusaders hockey teams and also serves as physician for the U. S. Ski Team in world-wide competitions.

## Tax Credit Available for Hiring Eligible Welfare Employees

The following information was contained in a release from the U. S. Department of Labor.

The Revenue Act of 1971 allows employers to claim a "Job Development Tax Credit" amounting to 20 percent of the cash wages paid an eligible welfare employee during his first 12 months on a company payroll.

To be eligible for this credit, employers must hire workers from the Work Incentive Program (WIN), operated through state employment security and welfare agencies. The program's long-range goal is to restore to economic independence all employable persons receiving Aid to Families with Dependent Children.

Thus, business or professional people hiring WIN workers benefit two ways—directly through the tax credit and indirectly by helping to reduce welfare rolls.

# NEW strength

# STRENGTH



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new 225 mg./5 ml.  
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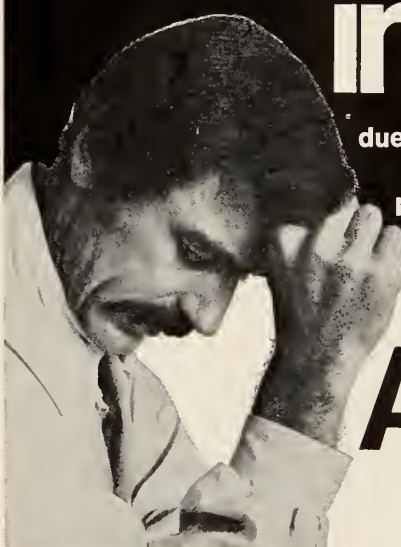
- \* 125 In-patient beds —
- \* Day Hospital program —
- \* Full time attending staff of psychiatrists —
- \* Professionally trained Adjunctive Therapy staff with programs in occupational, recreational and vocational therapy. (Crafts, Fine Arts, Greenhouse, etc.)
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- \* Consultation and evaluation for out-patients.

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Harding Hospital - Worthington, Ohio  
Area Code 614 - 885-5381

George T. Harding, M.D.  
Medical Director

Donald L. Hanson  
Administrator



The treatment of

# impotence

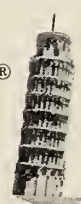
due to androgenic deficiency in the American male.  
The concept of chemotherapy plus the  
physician's psychological support is confirmed  
as effective therapy.

**NEW  
CLINICAL  
STUDY**

The Treatment of Impotence  
with Methyltestosterone Thyroid  
(100 patients — Double Blind Study)  
T. Jakobovits  
Fertility and Sterility, January 1970  
Official Journal of the  
American Fertility Society

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**Contraindications:** Android is contraindicated in patients with prostatic carcinoma, severe cardiac disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

**Warnings:** Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

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**Hypercalcemia** may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

**References:** 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of impotence. Clin Med 12:95, 1956. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Telford, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, O. K., and Gallagher, J. Thyroid-androgen interrelations and the hypochlosterolemia effect of androstereone. J Clin Endoc 11: 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:853, 1958. 6. Osel, A., and Farrar, G. E. United States Dispensatory (ed. 28). Lippincott, Philadelphia, 1955, p. 1432. 7. Werchub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Papers on Drug Abuse  
Available from OSMA Office

Copies of several papers on drug abuse from the AMA's 1972 Conference of State Mental Health Representatives are currently available from the OSMA office. Included are:

"How the Medical Society Can Involve Physicians in Drug Abuse Treatment," by Merlin W. Kampfer, M.D., president, Community Organization for Drug Abuse Control, Phoenix, Arizona.

"Emergency Treatment and Detoxification," by George R. Gay, M.D., director, Drug Detoxification, Rehabilitation and After Care Project, Haight-Ashbury Free Clinic, San Francisco, California.

"The Physician's Role in Educating the Public," by Wallace Ann Wesley, Hs.D., director, AMA Department of Health Education, Chicago, Illinois.

"AMA Activities in Drug Abuse," by Herbert A. Raskin, M.D., chairman, AMA Committee on Alcoholism and Drug Dependence, Birmingham, Michigan.

"Case Studies in the Development of Community Programs—Maricopa County," by William J. Dunn, M.D., vice-president, Community Organization for Drug Abuse Control, Phoenix, Arizona.

Also available as a public service from the OSMA office is the newly revised pamphlet "What Everyone Should Know About Marihuana, LSD, Amphetamines, Barbiturates, Glue Sniffing and Narcotics." Copies may be obtained in volume for waiting rooms, meetings, etc.

For copies of any of the above, contact the Secretary, Committee on Mental Health, Ohio State Medical Association, 17 S. High St., Columbus 43215.

VA Adds Another  
Drug Treatment Center

Dedication of a drug dependence treatment center at McGuire Veterans' Hospital in Richmond, Va., brings to 44 the number of drug treatment centers officially in the Veterans Administration system.

Veterans now can also get treatment for drug abuse at all of the 168 VA hospitals in every state of the continental U.S., and at special VA drug centers or units in 30 states, Puerto Rico, and the District of Columbia.

VA is admitting somewhat more than 22,000 drug dependent patients per year. This is about 1,200 inpatients and 6,000 outpatients daily, or some 70,000 outpatient visits per month.

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# State Medical Board Report Shows Increase in Enforcement Activities and Licensure

SOME INTERESTING DATA are revealed in the annual report of the State Medical Board of Ohio for 1971. During the year there was an approximate 500 percent increase in formal enforcement activity and an approximate 200 percent increase in licensure activities over the previous year.

The information is contained in the official report of the Board to the Governor and is signed by William J. Lee, Administrator.

The Board held seven regular and 11 called meetings during the year. Examinations were held in Columbus, June 15-17 and December 7-9. There were 33 days of formal hearings in 1971 as compared to six in 1970; and 37 days of informal hearings, compared to 24 informal hearing days the previous year.

The volume of examinations (Flex type) in 1971 almost tripled those of 1970. There were 541 examinations given in June and 442 in December, for a total of 983. This compares with a total of 337 given in 1970. This marked increase in volume is due to a recent change in the requirements for citizenship in applying for the examination, the report states.

Certificates issued in 1971 by examination numbered 465 for doctors of medicine, and one for doctors of osteopathic medicine. This compares with 227 certificates for MDs and two for DOs in 1970. Certificates were issued to 33 limited practitioners, and 66 physical therapists. Four certificates were issued in midwifery.

Certificates were issued in 1971 by endorsement to 750 doctors of medicine and 71 doctors of osteopathic medicine. This compares with cer-

tificates for 544 doctors of medicine in 1970 and 44 doctors of osteopathic medicine.

Certificates by endorsement were issued to five limited practitioners, 37 podiatrists, and 35 physical therapists.

Certificates of preliminary education were issued by entrance examiner to 2,005 MDs and DOs during the year, and to 188 limited practitioners.

Certificates issued during 1971 in the biennial registration of doctors of medicine for the period 1971-1972 numbered 20,583. (This figure includes a number of physicians who are practicing outside of the State, but wish to maintain their Ohio certificates.) During 1971, renewal of osteopathic licenses numbered 1,643. Reinstatement of certificates for doctors of medicine amounted to 216 and for osteopathic physicians, 18.

Temporary certificates were issued to doctors of medicine and to doctors of osteopathic medicine in the amount of 1,730. Seven limited certificates were issued to doctors of medicine; also three limited certificates were renewed.

Ohio licensees applying for out of state endorsement in 1971 numbered 554.

Investigators for the Board investigated 530 complaints of illegal practice during the year. A total of 4,299 calls were made in 79 Ohio counties, comprising investigations of licensed as well as unlicensed practitioners. Court actions were filed in 57 cases. At the end of the year, cases were awaiting trial, and convictions had been handed down in 15 cases. Fines were assessed in amount of \$1,800, and fines in amount of \$330 were collected.



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- ☐ Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin.
- ☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during November. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

#### CLARK

William M. Leahy  
Springfield

#### CUYAHOGA (Cleveland)

Lolita R. Agra  
Nabil F. Angley  
Mauricio Camacho  
Seung Man Cha  
Melvin J. Chavinson  
Claudio M. Contreras  
Carmen Dannug-Basug  
Charles J. Doyle  
Mine Ayse Kurtay  
Robert Alan Lewis  
Cyril E. Marshall  
Henry C. Romberg  
Jose M. Suarez  
Lucas G. Tan

#### HIGHLAND

Barbara Lustgarten  
Hillsboro

#### LORAIN

Daniel C. Zaworski  
Lorain

#### MONTGOMERY (Dayton, except as noted)

Lewis G. Anthony

#### Adolfo D. Baldemor

Suck-Jun Bang  
Rafael M. Cruz  
Gerard A. Dehner  
Gurdev S. Deol  
Elvira Rosca-Jaballas  
Fairborn  
Bento F. Ribeiro  
Mohammad R. Soleiman-  
pour

#### STARK (Canton, except as noted)

Leonard G. Knell  
Robert I. Lesowitz  
Louisville  
Edgardo A. Malacaman  
Vinayak T. Mehta  
Robert B. Miller  
David M. Montgomery  
Hector Salvucci

#### SUMMIT

Massood R. Babai  
Cuyahoga Falls  
John C. A. Chang  
Akron  
Rajdev Kaur Grewal  
Cuyahoga Falls  
Teofilo Tecson, Jr.  
Akron

## Changes in Title Approved At Toledo Medical College

Three changes-in-title for top level administrators at the Medical College of Ohio at Toledo, were approved by the MCO Board of Trustees at their meeting, November 20.

Dr. Robert G. Page, who has been dean of the Medical College since September 1, 1968, was named Provost—Academic Affairs. The title of Howard L. Collier, who became Vice-President for Administration in January 1971, was changed to Vice-President—Finance. And Robert Roberts, Sr. was named Director of Development after serving as Assistant to the President since August 1971.

The MCO Trustees promoted Liberato J. A. DiDio, M.D., to the newly created position of Dean of Graduate Studies. Dr. DiDio, the first faculty member appointed to the Medical College, will continue to hold his present position as professor and chairman of the department of anatomy.

The Board previously announced the appointment of Marion C. Anderson, M.D., as President of the College. (See page 1086 of the December issue.) Before that appointment he was professor and chairman of the Department of Surgery.

## Medical Education Congress Scheduled in Chicago

The 69th Annual Congress on Medical Education is scheduled to be held in Chicago, centered in the Palmer House, Friday-Sunday, February 9-11. It is presented by the Council on Medical Education of the American Medical Association in collaboration with the following other organizations: The Association for Hospital Medical Education, Association of Schools of Allied Health Professions, Federation of State Medical Boards of the United States, and the Student AMA.

Details may be obtained by contacting the Secretary, Council on Medical Education, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.



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**CEREBRO-NICIN<sup>®</sup> double-blind study\*  
shows how some senile symptoms can be treated.  
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Each CEREBRO-NICIN capsule contains:  
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AVAILABLE: Bottles 100, 500, 1000

**SIDE EFFECTS:** Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

**INDICATIONS:** As a cerebral stimulant and vasodilator.

**RECOMMENDED GERIATRIC DOSAGE:** One capsule three times daily adjusted to the individual patient.

**WARNING:** Overdosage may cause muscle tremor and convulsions.

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\*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D.  
Double-blind study on the treatment of mentally confused patients. Reprinted  
from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

# OMPAC Makes Good Record At Polls in 1972

ONCE AGAIN the Ohio Medical Political Action Committee chalked up a commendable record at the polls in the 1972 November General Election, despite the unusual twists and quirks which marked this year's election contests.

Take a look at the record in the following Box Score. It shows that OMPAC had an overall 70 percent winning score (92 in the U.S. Congressional races; 75 percent in the State Senate contests; and 66 percent in the Ohio House of Representatives battles.

THE 1972 OMPAC BOX SCORE

| Office      | Number of Candidates  |         | Amount of Support<br>From OMPAC |
|-------------|-----------------------|---------|---------------------------------|
|             | Supported<br>By OMPAC | Winning |                                 |
| U.S. House  | 12                    | 11      | \$52,800                        |
| Ohio House  | 73                    | 48      | \$24,025                        |
| Ohio Senate | 16                    | 12      | \$ 5,300                        |
| Totals      | 101                   | 71      | \$82,125                        |

### Candidates Carefully Checked

Candidates supported by OMPAC, regardless of political party, were selected as worthy of support by the OMPAC Board of Directors after:

- Careful analysis of the records of those who had held public office in the past.
- Evaluation of data regarding a candidate's character, standing in his community, educational qualifications and views on social, economic and public health-medical issues.
- Review of information and recommendations received from officials of state and local medical societies, plus comments from many individual physicians who were actively interested in the election of competent candidates.

In lieu of holding referenda among members of the medical profession—which would not have been feasible because of the large numbers of persons (physicians and candidates) involved, OMPAC made a special effort to secure advice

and suggestions from key physicians scattered throughout the state who were in a position to make judicious evaluations of candidates in their community.

Of course, a considerable number of candidates who did not receive financial help from OMPAC because they did not need financial assistance, had the active support of individual physicians and members of their families among their constituents.

The Ohio Medical Political Action Committee can be proud of its records in '66, '68, '70 and '72. The Ohio physicians, averaging about 2500 to 3000 annually, who have contributed to OMPAC are to be commended. They have played a major role in making the organized strength of the medical profession of Ohio felt in the political arena in election years. They have helped to elect many well-qualified persons to public office. Think what an impact the medical profession could make next year, and future years, if twice that number of physicians would support OMPAC with a \$25.00 contribution.

### What of 1974?

It is hoped that many more physicians will join the OMPAC team in 1973 and 1974, the latter being another crucial election year. Contributors in 1972 totaled 2393.

Now is the time for physicians to make 1973 OMPAC contributions of \$25.00, if they have not already done so. This should be done when paying 1973 local, state and national medical society dues. Local medical society secretaries will act as OMPAC agents in collecting the contributions and forwarding them to the OMPAC Columbus Office.

Pooling of the interest, activity and money of many, many individual physicians through the Ohio Medical Political Action Committee is what gives a real wallop to the medical profession's interest in good government and makes the profession a potent factor in political action.



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## In asthma, bronchitis...

"Many physicians use iodides intravenously when they suspect that the main reason for airway obstruction is sticky mucus but oral iodides are more likely to exert an expectorant action."<sup>1</sup>

"For the viscid sputum, potassium iodide (... preferable as enteric coated tablets) may be best."<sup>2</sup>

Provide tastefree, well-tolerated KI in convenient SLOSOL coated tablets—

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Each SLOSOL coated tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg.

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"The productive cough serves the necessary purpose of removing excess mucus from the bronchial tree."<sup>3</sup>

"... there is clear evidence that the loosening of the bronchial mucus blanket must begin from within the underlying mucus glands where it is anchored and not from the surface. Complications of iodides are too occasional to avoid the use of this valuable medication."<sup>3</sup>

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**INDICATIONS:** The primary indication for Iodo-Niacin is in any clinical condition where iodide therapy is desired. All of the usual indications for the iodides apply to Iodo-Niacin and include:

**RESPIRATORY DISEASE:** The use of Iodo-Niacin is indicated whenever an expectorant action is desired to increase the flow of bronchial secretion and thin out tenacious mucus as seen in bronchial asthma, and other chronic pulmonary disease. Iodo-Niacin has also proven of value in sinusitis, bronchitis, bronchiectasis, and other chronic and acute respiratory diseases where the expectorant action of iodide is desired.

**THYROID DISEASE:** Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy.

**ARTERIOSCLEROSIS:** Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

**OPHTHALMOLOGY:** Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption

of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

**SIDE EFFECTS:** Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous membrane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

**DOSAGE:** The oral dose for adults is two tablets after meals taken with a glass of water. For children over eight years, one tablet after meals with water. The dosage should be individualized according to the needs of the patient on long-term therapy.

**HOW SUPPLIED:** Cole's Iodo-Niacin tablets are available in bottles of 100, 500 and 1,000. Slosol coated pink. NDC 55-6458.

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Each SLOSOL tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg. Sig. *jj tabs. t.i.d. p.c.*

**References:** 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allergy. 29:367, 1971.



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*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*— George Sarton, from "The History of Medicine Versus the History of Art"*

**Are combination drug  
products useful in treatment  
involving concomitant use  
of two or more drugs?**

**Opinion**

**Results of a questionnaire to  
7,000 physicians:**

**62.9%**

**Believe combination drug  
products are useful.**

**13.8%**

**Do not believe combination drug  
products are useful.**



# Are combination drug products useful in treatment involving concomitant use of two or more drugs

## Opinion & Dialogue

### Doctor of Medicine

Louis Lasagna, M.D.  
Professor and Chairman  
Department of  
Pharmacology & Toxicology  
University of Rochester  
School of Medicine  
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in for a number of years, that have an apparent satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I'm thinking particularly of penicillin-streptomycin combinations that patients—especially surgical patients—were given in injection. This made less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosing errors. To take such preparation off the market doesn't seem to be good medicine, unless actual usage showed a great deal of harm from the injection (rather than the preparation) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA will play a major role in ruling this determination. In fact, I don't think it is avoid taking the ultimate responsibility, but it should enlist the help of other physicians and experts in assessing the evidence in making the ultimate decision.



# Maker of Medicine

Clarke Wescoe, M.D.  
President  
Inthrop Laboratories



two medications are effectively to treat a condition, and it is known that they are combinable, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact, it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of redundancy, the "expert" doctor prescribes the combination because it is a fixed dosage form. When the "expert" doctor makes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he imputes a pejorative meaning to the term "fixed dose" when he uses it with respect to combinations. It is ignored is the simple fact that only in the vast majority of circumstances can any physician attempt to elicit an exact therapeutic response in his patient. It is quite possible that some aches and pains respond to 500 mg. of aspirin yet that fact does not militate against the usefulness of a 650 mg. dose. The other semantic ploy called into play is to describe a combination product as rational or irrational.

Like antibiotic mixtures, the source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

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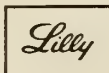
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VOLUME 69

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NUMBER 1

# The Doppler Ultrasonic Flowmeter

## Report of Its Use for Diagnosis of Peripheral Vascular Disease in the Smaller Community Hospital

LATHROP F. BERRY, JR., M.D., AND EDGAR L. LICHTI, PH.D.

**T**HE NEED FOR AN INSTRUMENT to quantitate and qualitate flow in the peripheral arteries subjectively and objectively has been obvious for many years. No such instrument has been available for use in the smaller community hospital that was not cumbersome, expensive, and usually unavailable when needed. The development of the Doppler ultrasonic flowmeter\* has made objective/subjective evaluation of vascular problems a reality for hospitals of any size.

In 1965, Strandness and Bell<sup>1</sup> described a technic for evaluation of peripheral vascular occlusive disease using mercury strain gauge plethysmography. This technic allowed the surgeon to monitor and evaluate vascular flow during and after a vascular procedure. The instrument does have several limitations and in recent years has been replaced in part by the Doppler ultrasonic flowmeter. Use of the ultrasonic flowmeter has been described by Lichti, et al<sup>2</sup> for the atraumatic evaluation of peripheral vascular occlusive disease and intraoperative use of the device has been

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described by Keitzer, Lichti, and DeWeese<sup>3</sup>. The adaptability of the instrument to the small community hospital is the purpose of this report.

The Doppler is a small, inexpensive, portable, battery-operated, electronic instrument which contains two piezoelectric crystals in a probe configuration for examination of peripheral vessels. The unit has an oscillator to drive the one piezoelectric crystal at natural resonating frequency of 10 MHz. This crystal is designated as the transmitter crystal. The second, or receiver crystal is used to detect changes in frequency caused when the beam of the transmitter crystal is reflected at a

Submitted June 13, 1972.

\*The Doppler ultrasonic flowmeters referred to in this article are produced and distributed by Parks Electronic Laboratories of Beaverton, Oregon.



slightly different frequency ( $f_d$ ) from the original because of contact with red blood cells in motion. The frequency difference is determined in cycles per second (cps) and is directly proportional to the velocity of blood flow in the vessel under observation (Fig. 1). The amplified  $f_d$  may be presented as an audible signal or as an analog signal on a graphic recorder or oscilloscope. Figure 2 is an analog presentation of a normal wave form. Figures 3 and 4 are the analog-wave form of an artery with a distal occlusion and oscillographic presentation of the sound of distal occlusion respectively. The sound pattern demonstrates the "water-hammer" effect noted with distal occlusion. Many factors influence the sound of the pulsatile wave form heard with the Doppler. Left ventricular output, vascular compliance, and peripheral resistance or occlusion are but a few.

Christian Johan Doppler described the principle, which bears his name, in early 1800's. The Austrian mathematician and physicist noted that there was a change in the pitch of a sound as the distance between the source and the listener was rapidly varied. A modification of this principle is carried into the ultrasonic flowmeter.

The Doppler ultrasonic flowmeter in use at our clinic is a self-contained, battery-operated unit which is relatively inexpensive and is readily available. Use of the unit is transcutaneous and atraumatic. It involves no morbidity or mortality and is well accepted by the patient, for it carries with it a saving of time and money. Use of the Doppler requires interpretation of sound. Experience in the interpretations can be gathered by listening to normal vessels, eg, the brachial artery or the pedal arteries, in normal healthy individuals. Venous disease may also be detected with the Doppler, but this does require some expertise with the instrument and a good knowledge of the venous anatomy. Once the operator of the instrument is familiar with normal arterial flow, abnormalities fall into

place rather easily. The physician is soon able to detect distal arterial occlusion. He may become accustomed to the sound by listening to the radial artery while tightly clenching his fist. He will then hear the "water-hammer" shown in Figures 3 and 4. If he maintains a clenched fist for several minutes and releases it while keeping the probe on the radial artery, he will hear the sound of reactive hyperemia. Collateral flow can be easily ascertained, for there is an elongated systole and a decrease or total loss of arterial compliance. The sound of collateral flow in the pedal arteries is a sign of a proximal arterial compromise, and the analog picture of the collateral flow on an oscilloscope best resembles a sine wave.

Venous patterns are a bit more difficult to master. Sigel, et al<sup>4</sup> have demonstrated that the Doppler ultrasonic flowmeter examination is much more reliable than clinical appraisal alone in the diagnosis of deep venous disease of the lower extremity. It is important to remember, when examining veins with the Doppler, that venous flow is phasic with respiration and that continuous venous flow or lack of venous flow, when augmentation is performed, are abnormalities. Venous valvular incompetence may be determined with the Doppler by augmentation of venous flow proximal to the probe. If flow is heard to the distal position, the diagnosis of venous valvular incompetence may be made. In an occluded femoral vein, sounds of venous flow will be heard from the greater saphenous vein and will be continuous and not phasic with respiration. Continual collateral venous flow, which is non-phasic with respiration and does not respond to a Valsalva maneuver, may be noted in the groin area of the patient with

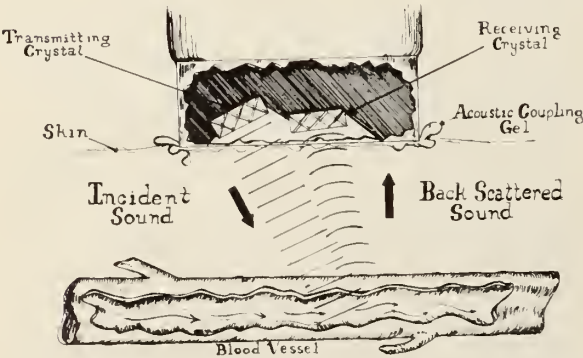


FIG. 1. Schematic diagram of blood vessel being examined with Doppler ultrasonic flowmeter probe.

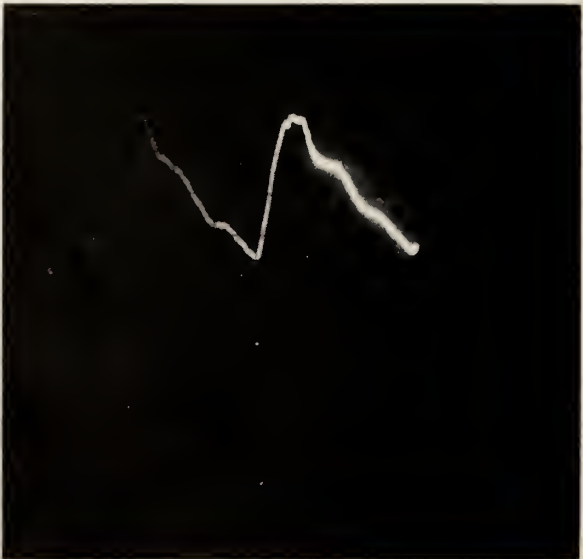


FIG. 2. Tracing of normal velocity wave form (analog) as seen on oscilloscope.





FIG. 3. Tracing of velocity wave form (analog) of artery with a distal occlusion.



FIG. 4. Tracing of velocity wave form (sound spectrum) of artery with a distal occlusion.

deep femoral venous occlusion. Use of the ultrasonic flowmeter to distinguish between arterial and/or venous circulatory problems without arteriography is of considerable value to the general surgeon in practice in the smaller community. It also saves time, trauma, and money for the patient.

Evaluation of the extent of peripheral vascular arterial occlusive disease is rather simple with the Doppler ultrasonic flowmeter and a blood pressure cuff. First the brachial artery pressure is obtained in each arm using the standard cuff and manometer and the Doppler to determine return of flow after cuff release. The pressure at which the first sound of flow is heard at a point distal to the cuff after release is the systolic pressure of the arm. Pressures are taken in both arms and pulses are compared. Comparison of pulses and pressure (sound and pressure being the same in each arm) will help to rule out the subclavian steal syndrome.

Pressures are then obtained at four points in each leg, using the posterior tibial artery or dorsalis pedis artery to determine the point of return of flow with the Doppler ultrasonic flowmeter. The points at which pressures are taken with the occlusive blood pressure cuff are at the ankle, below the knee, above the knee, and at the high thigh. In an individual with normal vasculature, it is a rule of thumb that the systolic pressure noted at the ankle should equal the arm pressure  $\pm 10$  mm Hg. The velocity wave sound of the vessel should have at least two of the sounds of a normal vessel, a sharp systole and a snap of arterial compliance. If the pressure at the ankle is within normal limits and the velocity wave contour has a normal sound, the patient's problem is probably not due to arterial insufficiency. If the pressure at the ankle

is below normal and if the patient experiences claudication, then the segmental pressures are obtained. The systolic pressure between any two points on a leg should not differ by more than 20 mm Hg. If a greater difference is noted in a segment, it must be considered that the segment of the lower extremity is the site of the occlusive disease (major).

In order to demonstrate the use of the Doppler Ultrasonic flowmeter in the clinical setting of the small hospital we present several case reports in which the device was used.

### Case Reports

**Case 1.** A 49-year-old white, male minister presented with apparent claudication in the right calf when exercising. Doppler studies showed the brachial artery pressures to be 112 mm Hg, bilaterally. Ankle pressures were 130 mm Hg at the right ankle and 132 mm Hg at the left ankle. Posterior tibial and dorsalis pedis arteries were present bilaterally. Femoral artery flow was normal and audible presentation of the pulsatile vessels was heard by the patient and discussed with him. With the reassurance that he was not in an advanced state of "hardening of the arteries" and that his pulses and pressures were in the normal range, the patient's symptoms disappeared. This patient was diagnosed and reassured without expensive, painful, and time-consuming arteriography.

**Case 2.** A 55-year-old male complained of bilateral claudication, greater in the right than left leg, of three years' duration. At the time of the patient's visit he could walk only one city block before stopping because of severe claudication. Physical examination showed no pulses below the femorals, which were manually palpable. Doppler examination showed a brachial pressure of 150 mm Hg. Right ankle pressure was 80 mm Hg, and the same pressure was noted with the cuff below the knee. Above the right knee the pressure was 88 mm Hg, and the right high thigh read 100 mm Hg. Pedal pulses, noted by Doppler were of the collateral type and no flow could be heard in the right femoral artery. The left leg presented with 90 mm Hg at the ankle and below-knee positions. Above-knee position read out at 100

mm Hg, and the high thigh was 130 mm Hg. A tentative diagnosis, based on Doppler findings of aortoiliac occlusive disease with total occlusion of the right iliac artery was borne out by arteriography. An aorto-femoral bypass was performed which allowed the patient to return to gainful employment after an uneventful postoperative course. The original diagnosis was made with the Doppler, and when the patient elected to have corrective surgery, arteriography was performed.

**Case 3.** A 78-year-old male was seen in the emergency room where the referring physician stated that the patient's swollen extremities contained no pedal pulses. The Doppler demonstrated bilateral pedal pulses with ankle pressures better than 200 mm Hg. The patient's arm pressure was 176 mm Hg. A diagnosis of no significant peripheral vascular arterial occlusive disease was made in a few minutes, and the patient was later found to have bronchopneumonia and mild congestive heart failure.

**Case 4.** A 50-year-old man was seen after an automobile accident in which his left thigh was badly lacerated. The leg became quite swollen, cold, and pulseless. The referring physician expressed concern about injury to the femoral artery. Ultrasonic flowmeter examination demonstrated a brachial artery pressure of 130 mm Hg with the blood pressure cuff and 125 mm Hg ankle pressure in the left leg. The pedal pulses were of normal sound with the Doppler. Examination of the left groin area with the flowmeter demonstrated closure of the femoral vein but evidence of collateral venous return was noted throughout the area. On the basis of these findings, a diagnosis of deep femoral thrombophlebitis was made and the patient was treated with anticoagulants. An uneventful recovery followed.

**Case 5.** A 77-year-old white woman was seen by her physician and referred with a history of right leg pain for 48 hours which had increased significantly on the day of admission to the hospital. Physical examination showed the leg to be cool from the calf distally and no pulses, including the femoral, were palpable. Pulses noted in the leg (with the Doppler) were weak, and pressures could not be obtained. Femoral artery pulsations in the right leg were of collateral flow. On the basis of the information obtained with the Doppler, a diagnosis of iliac obstruction secondary to embolus (the patient was in atrial fibrillation) was made. At surgery, a large embolus and secondary thrombus was removed with Fogarty embolectomy catheters from the right iliac artery. Flow to the lower extremity was restored and the limb was salvaged.

### Summary

The Doppler ultrasonic flowmeter can be highly useful in the smaller community hospital as an aid to preliminary diagnosis. Use of the

Doppler is not intended as a replacement for arteriography but rather as a tool which can complement the art of the radiologist. In several instances, the Doppler has been used in lieu of arteriography in emergency surgical procedures and this use has been reported<sup>5</sup>.

Venous problems have been detected with the ultrasonic flowmeter, and the use of the instrument for detection and diagnosis of venous disease has been reported<sup>4</sup>.

It is necessary to spend some time with the Doppler so that one can learn the normal sounds of blood vessels. After the normal sounds are mastered, the abnormalities of flow in vessels are easily detected. The Doppler probe can be gas-sterilized and used in the operating field thus providing an instant, audible display of the hemodynamics of the vascularity under observation.

The Doppler ultrasonic flowmeter represents a practical, relatively inexpensive, atraumatic, transcutaneous method of evaluating peripheral arterial and venous flow in the hospital or office. The use of the Doppler is analogous to the use of the stethoscope. If one would listen to heart sounds, he would use a stethoscope. If a physician is interested in bloodflow in peripheral vessels, he will use the Doppler ultrasonic flowmeter.

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# Lung Cancer Survival

## The Ohio State University Hospitals

JOHN P. MINTON, M.D.; MICHAEL S. SABBACK, M.D., AND KATHERN V. OBERLE

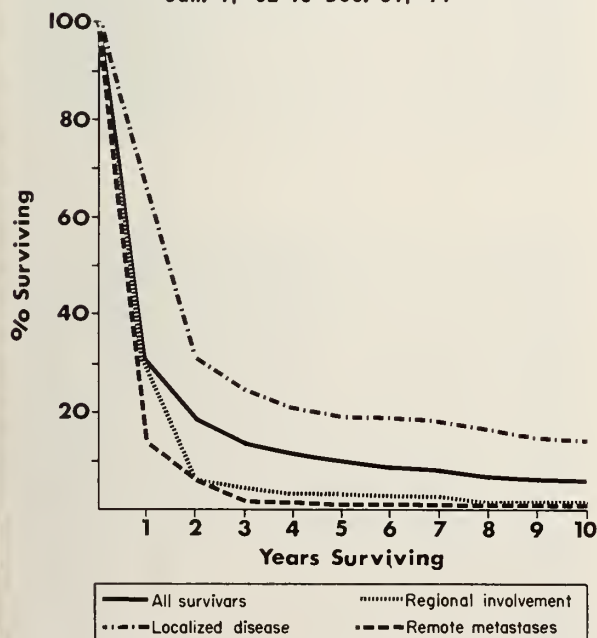
IT IS WELL KNOWN that bronchogenic carcinoma is the leading cause of male cancer deaths in the United States today. Recent reports have shown that the incidence of this disease is rapidly rising in both men and women in contrast to the stable or declining incidence of most other forms of cancer.<sup>1</sup> An undeniable relationship exists between cigarette smoking and the development of bronchogenic carcinoma. The disease offers a poor prognosis regardless of stage and initial treatment. (See chart).

Since 1962, The Ohio State University Hospitals have accumulated 1884 cases of bronchogenic carcinoma in its computerized cancer registry with a 99.99 percent accurate follow-up. In this report, the life-table method is used to compute yearly survival for our 1,956 patients.<sup>2,3</sup> Survival is

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- Mrs. Oberle, Columbus, is Assistant Director of Medical Records, The Ohio State University.

**LUNG CANCER SURVIVAL\***  
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\*The Ohio State University Hospital

calculated separately to provide a correlation between stage and prognosis for patients with localized disease (606), for patients with regional involvement (763), and for patients with remote metastases (515).

The survival curves displayed in the chart demonstrate that mortality from this disease is highest in the first three years regardless of stage. Almost all patients with regional and remote involvement at diagnosis are dead after two years. For patients with localized disease, the survival becomes constant after the third year. These results imply that three rather than five years may be the appropriate interval to consider patients without evidence of recurrence or metastases to be cured.

The uniformly fatal nature of this neoplasm in patients with regional and remote dissemination at diagnosis suggest that it has a highly malignant potential and that host resistance factors (immune system) may be unable to check tumor progression from the onset of disease.

**Acknowledgment:** The authors are grateful to Charles E. Little, Director of Data Processing, The Ohio State University, for his cooperation in providing these data.

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This investigation was supported in part by Public Health Service training grant 5T12-CA08110-07 from the National Cancer Institute.

Submitted March 27, 1972.



# Amniotic Bands as a Cause of Fetal Deformity

## Case Report with Discussion

OTIS G. AUSTIN, M.D., AND EDWARD L. FARNHAM, M.D.

THE FOLLOWING CASE presentation illustrates a purely mechanical cause for one type of deformity of a newborn infant. Much emphasis has recently been placed upon chromosomal causes for fetal deformity. The following case may be a reminder to fetologists and everyone involved with the care of pregnant women that a fetus which is being damaged by its intrauterine environment may, theoretically at least, be benefited by early diagnosis of condition. We concede that surgical procedures on the fetus are adventuresome, although amnioscopy is being done frequently.

### Case Report

Our patient was a 39-year-old black woman, gravida 9, para 4, who had four living children, had spontaneously aborted four early pregnancies and had undergone uterine dilatation and curettage after three of them. She had had no major surgical operations. She had received one postabortal blood transfusion in 1961. Her husband was 51 years old and in good health.

Her first prenatal checkup occurred in the third month of the pregnancy under consideration, and she was found to be in generally good condition. Basic laboratory findings were within normal limits; blood group was B, Rh D positive; and VDRL test for syphilis was negative. Expected date of confinement was September 11, 1966. Prenatal care was judged as being adequate, and the patient was admitted to the maternity wing on September 8, 1966 after the spontaneous onset

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of labor. Her membranes had ruptured shortly before admission, and after 15 hours of nonproductive labor, the baby's head remained in a persistent posterior position at midpelvis and with incomplete cervical dilatation despite hard contractions and no obvious fetopelvic disproportion. A low, vertical cesarean section was performed under spinal anesthesia, delivering a baby boy weighing 3,260 gm (7 lb 3 oz) but with unexpected difficulty. The head was lifted out of the pelvic inlet, and the shoulders and body were delivered easily, whereupon considerable confusion developed. The left foot was firmly confined to the area of the fundus by a firm, fibrous band of membrane, about 7 cm long and 1 cm in diameter, which had to be severed before the delivery could be completed. The placenta and membranes were stripped out of the uterus without difficulty, the only visible abnormality being the previously mentioned amniotic band. The baby's left foot presented a frightening appearance as it was blue and edematous, the skin being quite friable and loose (Fig. 1). At first glance, this part of the extremity seemed to be a possible subject for am-

From the Departments of Obstetrics-Gynecology and General Surgery, Medina Community Hospital, Medina, Ohio.  
Submitted April 5, 1972.

putation. The baby was examined by a pediatrician and found to have no other obvious anatomic or physiologic variations. A surgical consultant also evaluated the baby. Figures 2, 3, and 4 indicate the changing appearance of the damaged lower extremity in chronologic order. The mother's post-operative course was uneventful.

Discussion

Descriptions of this type of fetal abnormality are either very short or are missing completely from the standard obstetric textbooks consulted. Torpin,<sup>1</sup> in 1965, presented an extensive paper relating his observations over more than 30 years of obstetric practice. He provided an excellent historical resume of reports and speculations regarding fetal malformations that had been published over the past 150 years. Apparently there

had been considerable skepticism among geneticists, pathologists, obstetricians, and other observers through the many years and a lack of enthusiasm in accepting the concept of fetal environmental conditions causing deformities, or more dramatically, amputations of extremities. A close look at the uterine contents during pregnancy may make the concept more acceptable.

The fetus normally lives in a closed sac containing amniotic fluid. The amnion is a multi-layered membrane, essentially fetal epidermis, extending over the umbilical cord and lining the chorionic cavity. Outside and adjacent to the amnion is the chorion, including the placenta, fetal mesodermic in origin, and in turn covered with maternal decidua. If the amnion ruptures during early pregnancy and, particularly if the chorion also ruptures, abortion would seem likely. If a small defect in the amnion occurs in late



FIG. 1. Left foot of neonate (3 days). Note groove from amniotic band.



FIG. 2. Same foot at age 2 months.



FIG. 3. At 3½ years of age.



FIG. 4. At 5 years of age.

pregnancy but “seals over,” it is not unusual to have the pregnancy continue. If, on the other hand, the chorion does not rupture when the amnion becomes detached completely or incompletely, the outer surface of the amnion and, probably to a lesser extent, the chorion may produce fibrous strings or adhesions capable of entangling fetal extremities. The umbilical cord or the fetal neck could also be encompassed by these string-like structures. Oligohydramnios resulting from premature loss of amniotic fluid may give rise to pressure on fetal parts and resulting abnormalities such as clubbing of the feet or maldevelopment of the ears. Smith, et al,<sup>2</sup> in 1965, presented an extensive discussion of gangrene of the extremities in the newborn and infant, reporting five cases. They reported 59 previous cases in the literature dating back to 1828, but some of these cases may be attributed to intravascular clotting phenomena or localized maldevelopment of the vascular system.

Mansfield and Knight,<sup>3</sup> in 1963, reviewed the theories of etiology of congenital amputations and

classified them as “endogenous” arising from primary failure of development and “exogenous” as from intrauterine constrictive amputations. Familial incidence of congenital amputation is apparently rare and usually no other anomalies occur in the affected children.

### Surgical Considerations

Shortly after its birth we proceeded to debride this newborn's ankle area, which looked as though it was suffering from prolonged application of a tourniquet. The skin of the foot was edematous, weeping, blistering, and had small ulcerations. However, the foot appeared viable, so we elected to treat it with repeated cleansing and application of antibiotic creams. At that time, we could not evaluate the status of the tendons or deeper structures.

The ankle and foot improved rapidly, and upon discharge from the hospital, the involved foot nearly resembled the contralateral one. Over



the past five years, the boy has been periodically evaluated, and at this time, he has no obvious abnormality in his gait, balance, or in the use of the foot and ankle. The only changes evident now are the skin pigmentation and the presence of a circular scar which has proceeded to expand in circumference as the child grows (Fig. 4). There is no further evidence of any tourniquet effect from the scar itself. The boy is as active and playful as any 5-year-old child would be.

Summary

A case is presented to document one cause of a birth defect which, if recognized, could theoretic-

cally be treated during gestation. A premature "high leak of the membranes which seals" may be implicated in formation of bands which constrict fetal parts.

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E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

This 40-year-old lady enters with a raised lesion on the dorsum of her lip. This has been present for about nine months and has been gradually enlarging (Fig. 1).

What is her most likely diagnosis and what methods are available for diagnosis and treatment?

(See p. 47 of this issue for further information and discussion.)



FIG. 1. Raised lesion on dorsum of patient's lip.

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Submitted March 28, 1972.

# Milk-Alkali Syndrome

## Report of a Case Presenting with "Respiratory Failure"

ALI SADOUGHIAN, M.D.; JAHANGIR CYRUS, M.D.; AND HASSAN MEHBOD, M.D.

IN 1923, HARDT AND RIVERS first described "toxic" manifestations of milk-alkali treatment for peptic ulcer.<sup>1</sup> The manifestations were mostly those caused by hypercalcemia and transient renal failure. In 1936, Cope<sup>2</sup> stressed the hypercalcemia caused by this treatment. He also believed that some of the symptoms were due to hypermagnesemia.

The term milk-alkali syndrome was first used by Burnett, et al, in 1949 when they described cases with the following picture: history of prolonged and excessive intake of milk and absorbable alkali, hypercalcemia, azotemia, mild alkalosis, calcinosis (especially band keratopathy), and absence of hypercalciuria, hypophosphatemia, or elevated serum alkaline phosphatase level.<sup>3</sup>

Since absorbable antacids are not commonly used in therapy of peptic ulcer, this syndrome is a rare entity today. Recently, we had the opportunity to observe a typical patient with this condition, who also demonstrated striking arterial gas abnormalities.

### Case Report

A 30-year-old white man was admitted to the Veterans Administration Hospital, Dayton, Ohio, on August 17, 1970, with the chief complaint of epigastric pain of several years' duration with gradual worsening during the previous year. He had been diagnosed as having a duodenal ulcer in

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1968 and since then had been drinking three gallons of milk and taking 20 to 25 Alka-Seltzer tablets daily.

On physical examination he was thin and pale. Blood pressure was 110/60 mm Hg; pulse rate 90 beats per minute; respirations were 12 per minute; and temperature 36.0 C (98.4 F). There was no evidence of band keratopathy. There was some epigastric tenderness. In spite of polyuria of 4 to 5 liters daily, blood urea nitrogen and serum creatinine levels were elevated.

The laboratory findings with relation to the treatments given can be seen in Figure 1.

It should be noted that on August 21, 1970, and again on August 26, 1970, apparently because

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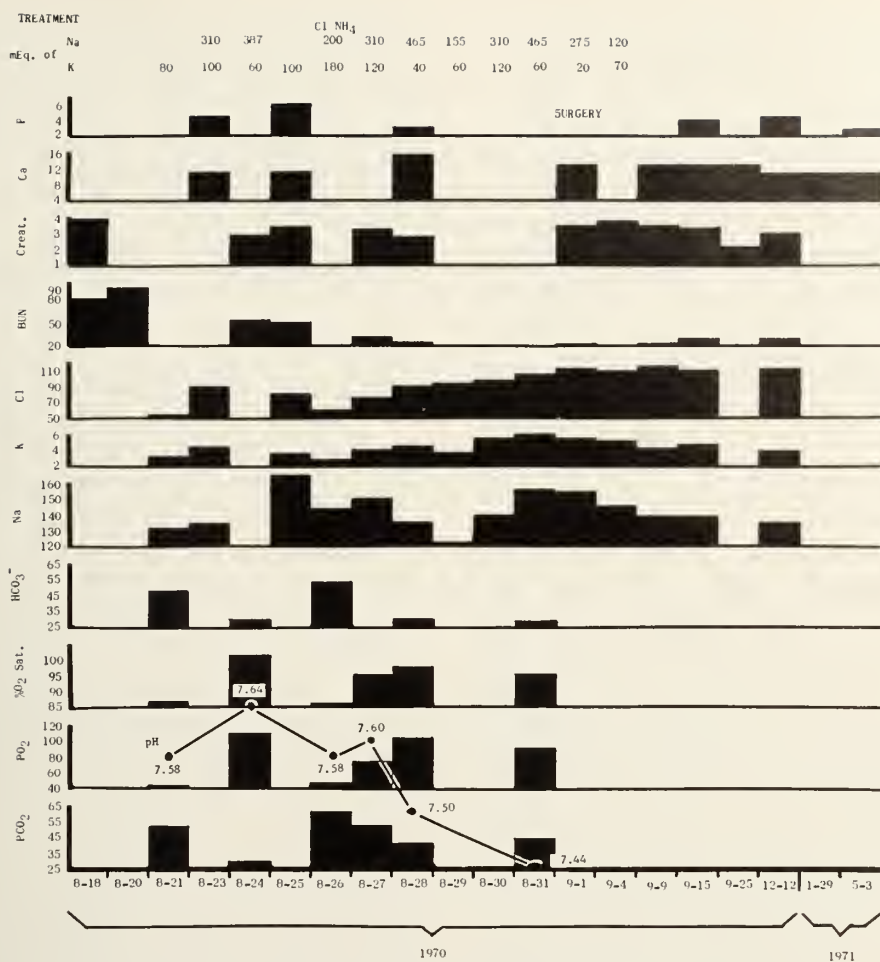


FIG. 1. Laboratory values in relation to treatments given.

of severe symptomatic hypoxia, he was treated with intermittent positive pressure breathing, which was stopped as alkalosis was aggravated.

On August 24, 1970, the patient began vomiting coffee-ground type material and went into shock. Clinical findings confirmed the diagnosis of upper bowel obstruction. After initial treatment aimed at correcting the metabolic alkalosis, transfusion of several units of blood, and administration of oxygen, he improved sufficiently enough to be operated on September 2, 1970, and he was found to have an ulcer 2 cm distal to the pyloric sphincter. Vagotomy and gastrojejunostomy were done. The patient did well postoperatively.

Kidney biopsy was performed on September 24, 1970. This revealed nephrocalcinosis and chronic interstitial nephritis (Fig. 2). The patient has been followed on an outpatient basis ever since. Presently, he is asymptomatic. He has gained over 30 pounds since the operation. Laboratory studies are all within normal limits except for serum creatinine, which has remained at 2 mg per 100 ml.

## Discussion

This patient presented with all the features of milk-alkali syndrome. It is interesting to note that he had ingested approximately three gallons of milk and over 500 mEq of bicarbonate a day.

The mechanism of production of hypercalcemia in this patient is not clear. In 1949, Burnett, et al<sup>3</sup> discussed the possibility of primary hyperparathyroidism. However, against the diagnosis of primary hyperparathyroidism are lack of hypophosphatemia, hypercalciuria, lowering of the serum calcium with low calcium intake, and absence of skeletal demineralization. The fact that our patient's serum calcium gradually returned to normal and has remained normal ever since is also strong evidence against the possibility of hyperparathyroidism. Other evidence against hyperparathyroidism was a urinary calcium way below calcium intake (70 to 238 mg per 24-hour urine) on a 250 mg calcium diet (higher urinary calcium values during alkalosis).

Hamburger and Walsh<sup>4</sup> believed that hypercalcemia cannot be explained by high calcium



intake because it is absolutely an inconstant factor. One will then have to postulate the presence of some hypercalcemic factor acting by an increase in intestinal absorption and/or by mobilization of bone calcium. However, there was no evidence of bone demineralization in this patient nor in any other reported cases.

Heinemann<sup>5</sup> relates alkalosis to hypercalcemia and postulates that it is due to greater availability of buffering capacity of the skeleton, secondary to mobilization. The most likely explanation for alkalosis and hypercalcemia, at least in this case, is the excessive intake of both alkali and calcium whereas other mechanisms postulated above could not be documented.

Another feature of this syndrome is hyponatremia which was seen early in this patient. Although vomiting alone could do this, many other factors were probably at play. For example, movement of  $\text{Na}^+$  into the cell as  $\text{H}^+$  and  $\text{Na}^+$  replacing  $\text{K}^+$  in the cell is certainly a reason for hyponatremia in some cases. Indeed, during hyponatremic period, urinary  $\text{Na}^+$  was much less than after recovery (70 to 180 mEq per 24-hour with the same  $\text{Na}^+$  intake). This observation militates against urinary  $\text{Na}^+$  loss as a cause, at least in this case.

A striking feature demonstrated in this case is severe hypercapnea coinciding with the period of metabolic alkalosis. For example, on August 26, 1970, when pH was 7.58,  $\text{PO}_2$  was less than 50, and  $\text{PCO}_2$  was 60, which by definition is "respiratory failure." Arterial gas values returned to normal only after correction of alkalosis. Hypo-

ventilation was a manifestation of metabolic alkalosis and due to an inhibitory effect of the lack of  $\text{H}^+$  on the respiratory center. This degree of hypoventilation simulating the  $\text{PCO}_2$  and  $\text{PO}_2$  of respiratory failure is a very interesting feature and has been occasionally observed by us, but to a much lesser degree, in other conditions associated with metabolic alkalosis.

In 1962, Zeffren and Heinemann described the reversible defect in renal concentrating mechanism in patients with hypercalcemia. It is believed that calcium inhibits the action of antidiuretic hormone resulting in polyuria in hypercalcemic patients as was also well demonstrated in this case.

Renal pathology as seen here included nephrocalcinosis, glomerular sclerosis, and varying degrees of tubular lesions ranging from necrosis of epithelium to spotty deposition of calcium in the basement membrane. The collecting ducts are chiefly involved. While calcium can be incriminated as a cause of tubular changes, the reason for glomerular sclerosis is not clear at all.

It is not unlikely that patients periodically taking milk and absorbable alkali for ulcer symptoms may have similar but milder and unrecognized episodes resulting in subclinical but permanent renal damage.

### Summary

Milk-alkali syndrome, a result of excessive intake of milk and absorbable alkali in patients with peptic ulcer disease, is a rather rare entity today. Prominent features include: alkalosis, hypokalemia, hypercalcemia, hyponatremia, and disturbed renal

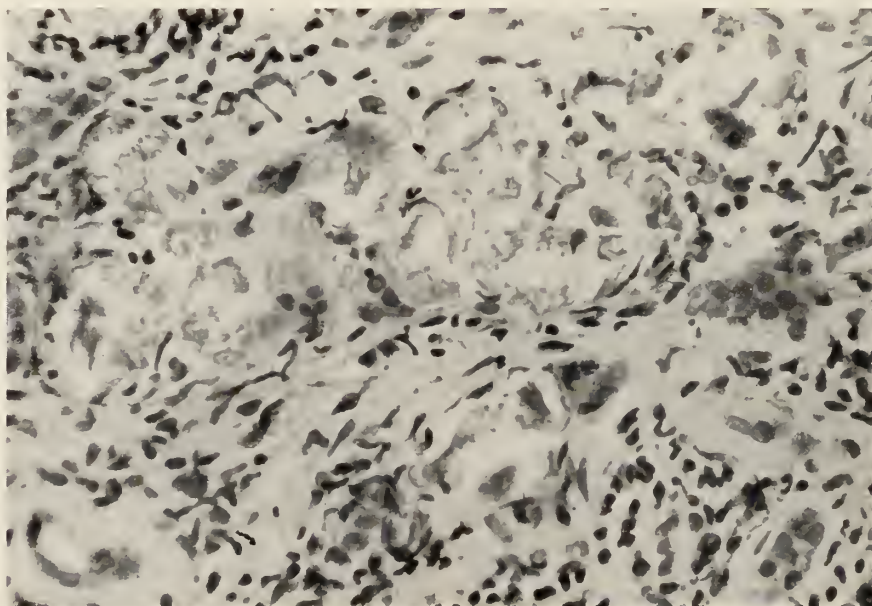


FIG. 2. Kidney biopsy demonstrating area of nephrocalcinosis and interstitial cell infiltration.

function ranging from defective concentrating ability to uremia.

We describe herein a typical patient who presented with hypoxemia and hypercapnea ("respiratory failure") and in whom successful treatment led to correction of all abnormalities except residual, impaired renal function.

**Generic and Trade Name of Drug**  
Effervescent antacid/analgesic — Alka-Seltzer  
(Miles Laboratories)

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**LET ME GIVE YOU FOUR QUOTATIONS:**

Firstly: "Our youth loves luxury, has bad manners, disregards authority and has no respect whatsoever for age; our today's children are tyrants; they do not get up when an elderly man enters the room — they talk back to their parents — they are just very bad."

Secondly: "I have no longer any hope for the future of our country if today's youth should ever become the leaders of tomorrow, because this youth is unbearable, reckless — just terrible."

Thirdly: "Our world has reached a critical stage; children no longer listen to their parents; the end of the world cannot be far away."

Finally: "This youth is rotten from the very bottom of their hearts; the young people are malicious and lazy; they will never be as youth happened to be before; our today's youth will not be able to maintain our culture."

The first came from Socrates, 470-399 B.C.; the second from Hesiod, circa 720 B.C.; the third from an Egyptian priest about 2,000 years B.C.; and the last was discovered recently on clay pots in the ruins of Old Babylon, and these were more than 3,000 years old.

I leave you with two thoughts? G. K. Chesterton said; "The only man who understood me was my tailor, who measured me afresh each time we met." When dealing with adolescents may I suggest that you measure them afresh each time you meet them — whether they be pupils or patients, sons or daughters, and no matter how short the interval between the meetings. And then, perhaps, we can take some consolation from Oscar Wilde, who said; "Children begin by loving their parents: as they grow older they judge them; sometimes they forgive them." — Ronald Gibson, C.B.E., London: *British Medical Journal*, 2:549-552, June 5, 1971.

# Anomalous Origin and Course of the Left Coronary Artery

## Report of a Case

MAJ. BARRY R. HERSCHMAN, MC, USAF, AND JACK W. C. HAGSTROM, M.D.

IN THE NOT-TOO-DISTANT PAST, coronary artery anomalies were anatomic curiosities. They were functionally insignificant or lethal. In the former instance, treatment was unnecessary; and in the latter, they were undiagnosed during life, resulted in sudden death, and were discovered at autopsy. With the advent of coronary angiography and cardiac surgery, a functional as well as an anatomic knowledge of anomalous patterns of coronary arteries has become essential.<sup>1-3</sup>

The following report presents a rarely described coronary artery anomaly and the embryogenesis, incidence, and clinical significance of coronary artery anomalies in general.

### Case Report

A 34-year-old man with no known prior history of cardiovascular disease was admitted to the University Hospitals of Cleveland because of fulminant pneumococcal pneumonia. Electrocardiograms showed left atrial and ventricular hypertrophy and left axis deviation. His temperature was 37 C.; pulse rate 80 beats per minute and regular; respirations 30 per minute; and blood pressure 130/70 mm Hg. There was clinical evidence of heart failure and he was treated for it, as well as for the pneumonia; however, he died of sepsis and cardiac and respiratory failure four days after admission.

The pertinent autopsy findings were confined to the lungs, kidneys, and heart. The pericardial sac contained 200 cc of serosanguineous fluid. The heart weighed 570 grams. The epicardium, myocardium, endocardium, septae, and heart valves were normal. The venae cava, pulmonary artery, pulmonary veins, and aorta

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Submitted June 26, 1972.

### The Authors

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were in their normal positions and interrelationships. The aortic sinuses of Valsalva were equal in size, and the aortic surfaces of the posterior and left sinuses were smooth and without a trace of dimpling. Three ostia were present in the aortic wall of the right sinus of Valsalva. The most anterior was less than 0.1 cm in diameter and gave rise to a conus artery, which transcended the pulmonary conus and terminated as multiple branches in the region of the midanterior longitudinal sulcus. Posterior to the ostium of the conus artery was a depression approximately 0.5 cm in depth and 1.0 cm in diameter. Within it were two ostia at the same level. The anterior ostium was 0.4 cm in diameter and gave rise to the right coronary artery, which followed a normal course with the expected number and location of branches. It terminated in the posterior wall of the left ventricle. The posterior ostium was also 0.4 cm in diameter and subserved a vessel analogous to the left coronary artery. It coursed behind the aorta and then in the sulcus between the left atrium and aorta, where it gave origin to a branch approximately 2 cm long and 0.1 cm in diameter which was in the position of the normal circumflex artery. The vessel then curved antero-inferiorly and ended as multiple branches in the anterior wall of the left ventricle (Fig. 1).

Atherosclerosis was not significant in any of the coronary vessels. The cardiomegaly was probably on a hypertensive basis as indicated by arteriolar nephro-



sclerosis. The lungs showed confluent bronchopneumonia with necrosis and abscesses.

### Discussion

The incidence of coronary artery anomalies as reported varies from 17 instances in 755 random autopsies<sup>4</sup> to 54 in 18,950 autopsies.<sup>5</sup> Absence of one coronary artery is rare.<sup>6-8</sup> Origin of one or both coronary arteries from the pulmonary artery is well documented but is not considered in this communication.

Plotz<sup>9</sup> notes that coronary artery embryogenesis is nearly complete when the human embryo reaches 0.18 cm in length. It has been demonstrated that the proximal and distal segments of the coronary arteries are derived from different

the left sinus,<sup>5,6,8,10,11</sup> and less frequently, the posterior sinus.<sup>6</sup>

There is little, if any, functional significance when all the coronary artery ostia arise from the aorta regardless of their site of origin. The same is true when the arterial pattern deviates from the normal.<sup>1,9,18</sup>

Review of the literature reveals that the anomalous coronary artery pattern discussed in this paper has been described twice before when found as an isolated cardiac anomaly,<sup>7,16</sup> once in conjunction with other cardiac malformations,<sup>11</sup> and once with an additional penetrating septal vessel arising from the right coronary artery.<sup>19</sup>

### Summary

Single coronary arteries, when they arise from the aorta, generally have no functional significance. Since they produce branches which deviate from the normal coronary arterial pattern, they may interfere with a desired surgical approach or, if unrecognized, may be injured during cardiac surgery. With the increasing use of coronary angiography it is likely that more coronary artery anomalies will be recognized during life.

A single right coronary arterial pattern which has been infrequently reported is presented. Embryogenesis of the coronary arteries with suggestions as to why malformations occur, reported coronary artery anomaly incidence, and the clinical significance of coronary artery anomalies are also presented.

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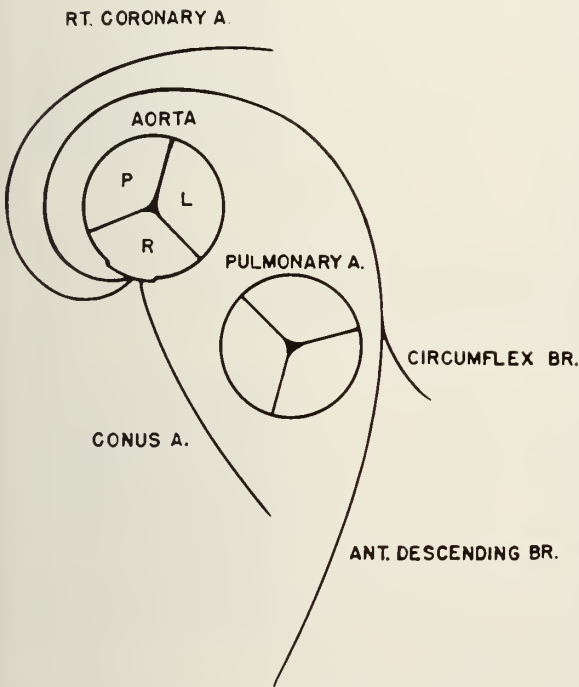


FIG. 1. Schematic representation of coronary artery vasculature.

anlagen.<sup>9-11</sup> Various mechanisms are offered regarding the pathogenesis of single coronary artery anomalies. Included are failure of the segments to fuse, with concurrent formation of interarterial anastomoses, complete absence of one coronary artery anlage, displacement of a coronary artery anlage so that one fuses with another, and occlusion of one coronary artery soon after its development with failure of canalization resulting in compensatory dilatation of the other coronary.<sup>6,10,11</sup> The conus artery should not be regarded as an anomalous vessel.<sup>12,13</sup>

Single coronary arteries have been described as arising from either the right sinus,<sup>3,6-8,11,14,17</sup>

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## NEPHROLOGY

# Drug Dosage in Renal Failure

LEONARD B. BERMAN, M.D.\*

THE VERY LARGE NUMBER of therapeutic agents in current use obliges the clinician to understand how renal failure may alter the dosage of some and not of others. Conventional treatment schedules are designed to achieve non-toxic blood levels, and these depend, in turn, on metabolic inactivation or urinary excretion of the active principle. If metabolic inactivation is the major route for a given agent, renal failure makes little difference. If urinary excretion is predominant, renal failure may impose a severe reduction in dosage. It is important to note that urinary excretion of the drug in its active form is under discussion here, rather than excretion of an inactive metabolite. Further, if high blood levels do result from renal failure, some clinical judgment is necessary concerning the possible toxicity of those

levels. These considerations can be illustrated by the examples cited below.

| Drug            | Urinary Excretion<br>of Active Drug | Toxicity from<br>Increased<br>Blood Levels | Reduce Dosage<br>in Renal Failure |
|-----------------|-------------------------------------|--|-----------------------------------|
| Penicillin      | Yes                                 | No   | No                                |
| Kanamycin       | Yes                                 | Yes  | Yes                               |
| Chloramphenicol | No                                  | Possible                                   | No                                |
| Digitalis       | Yes                                 | Yes  | Yes                               |
| Corticosteroids | No                                  | No   | No                                |

Several formulae have been published for calculating doses of particular drugs in renal failure. The practicing physician must regard his patient with renal failure as a unique pharmacologic challenge. Everything going in by injection or ingestion must be considered in light of a possible reduction or absence of excretion. The challenge is offered as much by water, salt, protein, and potassium as it is by medicinal drugs.

\*Dr. Berman is Chief of the Department of Nephrology, Mt. Sinai Hospital of Cleveland.  
Submitted February 8, 1972.

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**IMPORTANT INFORMATION:** This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdose or individual hypersensitivity, reactions similar to those after meperidine or morphine overdose may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

**Indications:** Lomotil is effective as adjunctive therapy in the management of diarrhea.

**Contraindications:** In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.


**Warnings:** Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

**Usage in pregnancy:** Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the

breast milk of nursing mothers.

**Precautions:** Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage not exceed recommended dosages. Administer with caution to patients receiving addicting drugs known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage. Strictly observe contraindications, warnings and cautions for atropine; use with caution in children since signs of atropinism may occur even with recommended dosage.

**Adverse reactions:** Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy.



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can cause  
diarrhea.**

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will almost  
surely stop it.**

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stlessness, euphoria, pruritus, angioneu-  
giant urticaria and paralytic ileus.

**administration: Lomotil is contraindi-  
cated in children less than 2 years old.** Use only  
for children 2 to 12 years old. For  
years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years,  
) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5  
adults, two tablets (5 mg.) t.i.d. to two  
) q.i.d. Maintenance dosage may be as  
fourth of the initial dosage. Make down-  
adjustment as soon as initial symptoms  
d.

Keep the medication out of the reach  
since accidental overdosage may cause  
fatal, respiratory depression. Signs of  
include flushing, lethargy or coma, hypo-  
leis, nystagmus, pinpoint pupils, tachy-  
respiratory depression which may occur

12 to 30 hours after overdose. Evacuate stomach by  
lavage, establish a patent airway and, when neces-  
sary, assist respiration mechanically. Use a narcotic  
antagonist in severe respiratory depression. Obser-  
vation should extend over at least 48 hours.

**Dosage forms:** Tablets, 2.5 mg. of diphenoxylate  
HCl with 0.025 mg. of atropine sulfate. **Liquid**, 2.5  
mg. of diphenoxylate HCl and 0.025 mg. of atropine  
sulfate per 5 ml. A plastic dropper calibrated in in-  
crements of ½ ml. (total capacity, 2 ml.) accom-  
panies each 2-oz. bottle of Lomotil liquid.

**Dosage forms:** Tablets, 2.5 mg. of diphenoxylate  
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sulfate per 5 ml. A plastic dropper calibrated in in-  
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### Clinical Data:

**Patient:** 47-year-old male.

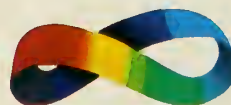
**Diagnosis:** Severe pyoderma, left hand.

**Culture:** *Staphylococcus aureus*, coagulase positive and sensitive to MINOCIN.

**Temperature:** 102° F

**Therapy:** MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat*, 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.

**Concomitant therapy:** None.†



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use has not been established in children under 13.

**Precautions:** Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

**Adverse Reactions:** (Common to all tetracyclines, including MINOCIN) GI: (with both oral and parenteral use): anorexia, nausea, light-headedness, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. **Skin:** maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). **Renal toxicity:** rise in BUN, dose-related (see "Warnings"). **Hypersensitivity reactions:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. **Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

**NOTE:** Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that MINOCIN is not notably influenced by foods and dairy products.

\*Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.

†Case Report, Clinical Investigation Department, Lederle Laboratories.



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

436-2



# Massive Autoagglutination, Hemolysis, and Hypergammaglobulinemia Triggered by Adrenocortical Steroids — A Case Report

JOSEPH A. LINSK, M.D.; SIDNEY S. GIRSH, M.D.; AND LEONARD B. ERBER, M.D.

**M**ASSIVE AUTOHEMAGGLUTINATION associated with acute hemolysis is a rare clinical event.<sup>1</sup> Most reported cases have been associated with high-titer cold agglutination disease secondary to viral infections.<sup>2-4</sup>

The triggering of this phenomenon by adrenocortical steroids which simultaneously produced massive lysis of lymphatic tissue and rise of immunoglobulins has not, to our knowledge, been reported.

Such a case forms the substance of this report.

## Case Report

A 46-year-old white male entered the hospital with a severe upper respiratory infection present with increasing intensity for two weeks. Three months previously, he had been treated for a febrile "virus infection" with an antibiotic (Declo-mycin). A blood count was normal.

On admission, he was acutely ill with severe headache, cough, sweats, and painful lymph nodes. Temperature was 37.2 C (99 F), rising rapidly to 38.3 C (101 F). Pulse rate was 104 beats per minute; respirations 22 per minute; and blood pressure 110/70 mm Hg. There was generalized lymphadenopathy. Nodes were discrete, tender, and varied from soft to rubbery consistency and from 1 to 2 cm in size. The lungs were clear. There were no heart murmurs. The liver was not palpated, and the spleen was felt 2 cm below the costal margin.

Chest x-ray revealed infiltrations consistent with bronchopneumonia and/or multiple infarcts.

The urine contained 30 per 100 ml albumin and normal sediment. The hematocrit reading was 36 percent, hemoglobin level 12.5 gm per 100 ml,

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red blood count (RBC) 4,000,000 per cu mm, white blood cell count (WBC) 8,200 per cu mm with 32 neutrophils, 53 lymphocytes, 1 monocyte, 7 eosinophils and 3 basophils. The sedimentation rate was 29 mm/ph (Cutler). Uric acid value was 8.0 mg per 100 ml, and other routine chemistry values were normal. The VDRL test for syphilis was nonreactive. Heterophile and cold agglutinins were negative and febrile agglutinins showed typhoid H positive 1:80, typhoid O positive 1:40; paratyphoid B positive 1:40, and paratyphoid A and C, *Brucella abortus*, and *Proteus* OX19 negative. Urine and blood cultures were negative.

By the fourth day, the patient's symptoms had intensified. He was toxic and drowsy. Lymph nodes and spleen were larger, and there were bilateral basal rales. The peripheral blood smear contained atypical lymphocytes suggestive of infectious mononucleosis. Bone marrow aspiration revealed a left shift in the myeloid series as well as scattered atypical lymphoid cells similar to the peripheral smear.

On the seventh day, temperature was 39.2 C (102.6 F) and the patient was toxic and dis-

oriented. Result of heterophil test was again negative. Hemoglobin level was 11.2 gm per 100 ml, and WBC was 6,600 per cu mm with 16 percent neutrophils, 83 percent lymphocytes, and 1 percent eosinophil. A diagnosis of typhoid fever was considered. Chloramphenicol 1 gm was given intramuscularly every six hours, and he was transferred to the intensive care unit.

There was no response to chloramphenicol after 24 hours. Tuberculin, coccidioidin, and blastomycin skin tests were negative. The patient was listed as critical, and intravenous hydrocortisone (Solu-Cortef) was started on the eighth hospital day in a dose of 100 mg every eight hours. There was immediate clinical improvement with lessening of headache, clearing of sensorium, and prompt drop of temperature to normal. Lymph nodes rapidly shrank and were not palpable in 24 hours. On the ninth day, although he was less toxic, his hematocrit reading was 15 percent, hemoglobin level 5.2 gm per 100 ml, and WBC 33,900 per cu mm with 85 percent lymphocytes, many atypical and plasmacytoid. Red blood cells could not be counted owing to autoagglutination. Serum obtained on this day was used for the following determinations: thymol turbidity 33.6 units; total bilirubin level 1 mg per 100 ml; serum glutamic oxaloacetic transaminase (SGOT) 26 units; lactic acid dehydrogenase value (LDH) 2,000 units. Sia water test was positive. Total serum protein was 10.1 gm per 100 ml with albumin 1.0 gm and globulin 9.1 gm. Protein electrophoresis done on

this specimen fractionated into albumin 13.2 percent,  $\alpha_1$ -globulin value 2.1 percent,  $\alpha_2$ -globulin 2.6 percent,  $\beta$ -globulin 3.7 percent, and  $\gamma$ -globulin, 78.4 percent. Immunoelectrophoresis demonstrated prominence of  $\gamma$ -globulin.

On the 11th day, hematocrit reading was 11 percent, and he was critically ill from anemia, although afebrile. Reticulocytes were 4 percent but nucleated red blood cells were up to 68 per 100 WBC. There was total gelation of all blood samples drawn in syringes at room temperature, 37 F, and into 37 F saline. No serum was available for studies or cross match. Blood-typing was impossible owing to agglutination which was obvious grossly. Red blood cells shaken in 37 F saline remained tightly agglutinated, imparting a grainy appearance to the suspension. Eight units of type O+ blood were transfused in four days, relying on a record of prior typing during World War II service. Steroids were discontinued, then increased, and finally tapered (Fig. 1). The antimetabolite mercaptopurine was added to the therapy. Although fever recurred for ten days, there was gradual improvement.

During the period of convalescence, there was gradual disappearance of the autoagglutination phenomenon, although mild changes were still present on the 22nd day. Serum levels on the 22nd day failed to demonstrate cold agglutinins. The direct Coombs test was reported weakly positive at this time, and no lupus erythematosus (LE) cells were detected. On the 23rd day, spinal punc-

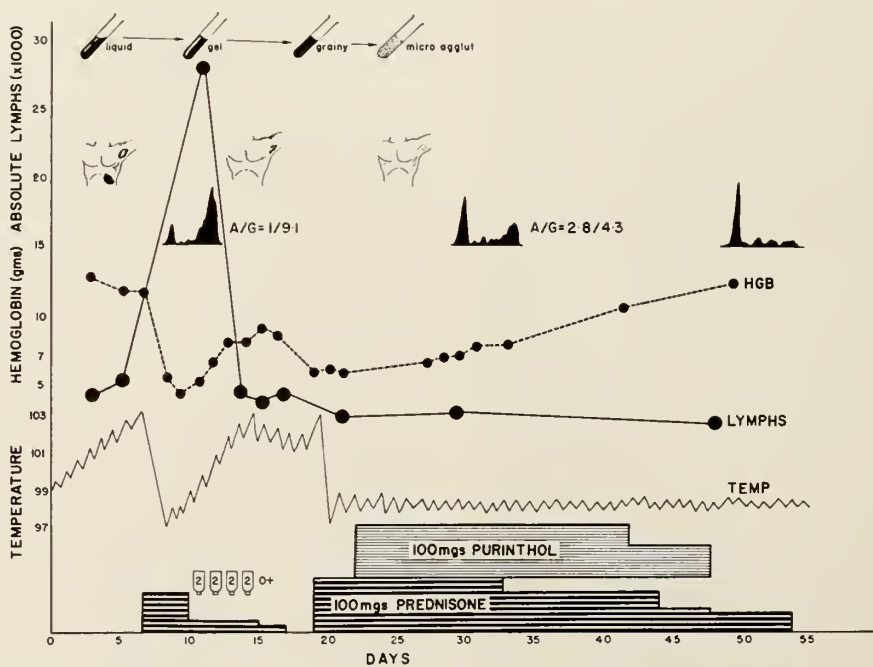


FIG. 1. Readings of temperature, hemoglobin, and absolute lymphs and proteins in relation to steroid therapy.

ture was performed and the results were normal. Blood and spinal fluid were submitted for virus study. Adenovirus antibodies were reported in the convalescent serum. At the same time, no evidence of virus was reported in stool and spinal fluid submitted to the state virology laboratory.

Serial serum electrophoretic studies disclosed a progressive drop in immunoglobulin and return of the pattern to normal, at which it remained three, six and 12 months after the acute episode. The findings are summarized in Figure 1.

### Discussion of Case

This patient had an acute respiratory infection with fever, toxicity, generalized lymphadenopathy, and splenomegaly. Clinical evidence favored a virus infection even though no organism was isolated. Adenovirus could have been implicated since respiratory as well as central nervous system disease have been reported with this agent.<sup>5</sup> It is possible, however, that some other unidentified viral agent was the cause of the syndrome. Infectious mononucleosis, however, seems unlikely since cough and tender nodes are not part of the clinical picture and two heterophil agglutinations were negative. The "virocytes" present on peripheral smear are common to many virus infections.<sup>6</sup>

Apart from the relationship to a virus infection, evidence for cold hemagglutination is sparse. Cold agglutinins were not present on admission, nor in the convalescent serum. Although these agglutinins may appear and disappear quickly,<sup>1</sup> a titer necessary to produce massive hemagglutination should have left some residual evidence. Wide amplitude cold agglutinins are promptly inactivated above 32 F in a great majority of cases.<sup>1</sup> In this case, the agglutination was tenacious at 37 F and could not be dissociated at 56 F.

Although a direct Coombs test was reported weakly positive on the 22nd day, this may have been false positive due to residual autohemagglutination or possibly the result of immunization by one or more uncrossmatched transfusions.

### Pathogenesis

From a theoretical point of view, the events in this case suggest an intense antigenic (viral) stimulus to the reticuloendothelial system forming high titer, intralymphatic antibody. The phenomenon was first demonstrated in 1935 by McMaster and Hudack who extracted high-titer agglutinins from lymph nodes after regional intradermal antigen injection.<sup>7</sup> Also, antigenic stimulation of lymph nodes in humans resulted in gross enlargement and marked reticulum-cell hyperplasia in postvaccination lymphadenopathy.<sup>8</sup>

Following the large steroid dosage, there was rapid shrinkage of lymphatic tissue evidenced by

palpatory findings. Coupled with this, there was a sharp rise in the absolute peripheral lymphocyte count and a massive rise in polyclonal gamma globulin. The effect of adrenal steroids on the lymphocyte includes shedding of cytoplasm and karyorrhexis.<sup>9</sup> Evidence concerning lysis of lymphocytes and release of antibody is conflicting, however. It has been produced experimentally,<sup>10,11</sup> but the lysing effect of ACTH, radiation, and nitrogen mustard did not cause an anamnestic rise in serum antibody titer in previously immunized cases.<sup>12,13</sup>

Although lymphopenia is the usual finding with steroid administration, lymphocytosis in this case might be explained by destruction of tissue lymphocytes, collapse of hyperplastic lymphatic tissue, and a "squeezing out" of lymphocytes into the circulation. A similar rise occurs initially in the treatment of chronic lymphocytic leukemia with steroids.<sup>14</sup> The leucocytosis is not a response to the massive hemolysis since that is almost invariably neutrophilic.<sup>6</sup>

The remarkable and apparently sudden rise in polyclonal immunoglobulin as demonstrated on paper electrophoresis occurred simultaneously with the gross contraction of lymphatic tissue. Although the *sia* test was positive, immunoelectrophoresis disclosed composition of the gamma globulin to be dominantly  $\gamma$ -globulin. Although no base-line electrophoretic pattern was available, the presumption of sudden appearance of hypergammaglobulinemia seems reasonable, since the complications of the hyperproteinemia (autoagglutination and hemolysis) were sudden. Further serial electrophoresis documented a return to a normal pattern (Fig. 1). The sudden rise would appear to confirm the release of preformed antibody.<sup>7</sup> Studies in laboratory animals suggest that intracellular IgG forms a pool from which antibody is secreted. *In vitro* studies demonstrated secretion from the intact lymphocyte (merocrine), rather than destruction of lymphocyte and release of gamma globulin (holocrine),<sup>15</sup> however, the massive shrinkage of lymphatic tissue and apparent release of gamma globulin suggest holocrine secretion in this case.

According to Ahlinder, et al, the extravascular pool of gamma globulin is as large as the intravascular pool.<sup>16</sup> Assuming a blood volume of 4,500 cc, and a plasma volume of 3,200 cc at hematocrit of 20 percent, this patient (with total protein of 10.1 gm) had 320 gm of intravascular plasmoprotein of which approximately 250 gm was gamma globulin. Including the extravascular compartment, the total gamma globulin would be 500 gm. Assuming a normal value for gamma globulin of 2.5 gm per 100 ml, there should be 62.5 gm in the intravascular pool and 125 gm in the combined intra- and extravascular pools (with plasma volume 2500 cc). In that case, 375 gm of gamma



globulin were released rather precipitously. This massive outpouring of polyclonal antibody is rare. An acute challenge with a potent antigen usually causes a rapid rise in specific antibody, but chemically measurable hyperglobulinemia is rare.<sup>17</sup>

A temporary rise in serum globulin to 5.6 gm per 100 ml was reported in one case of cold agglutination.<sup>3</sup> In a study of serum proteins in acquired hemolytic anemia, the findings were normal in 38 cases of the idiopathic warm-antibody type. There was marked elevation of gamma globulin with two cases of warm antibody due to disseminated lupus. In ten patients, with idiopathic cold antibodies with a titer greater than 8,000, autohemagglutination and an abnormal peak in the gamma I (macroglobulin) region were formed.<sup>2</sup> Further work demonstrated the identity of the gamma spike and the high titer antibody.<sup>18</sup>

The release of antibody globulin produced intense autohemagglutination. This has been described in the presence of high-titer cold agglutination.<sup>1</sup> In less marked form, it occurs when erythrocytes are heavily coated with incomplete warm antibodies;<sup>19</sup> it has been reported with virus infections<sup>20</sup> and following transfusion of plasma containing potent anti-A or anti-B.<sup>21</sup>

Hypergammaglobulinemia may produce "exaggerated" rouleau which appears much the same as true agglutination.<sup>6</sup> Although defibrination and dilution technics for distinguishing the two were not employed, the massive hemolysis clearly indicates agglutination, rather than rouleau. Autoagglutinating antibody produces hemolysis by damage to red cells and stagnation of blood in the spleen.<sup>1</sup> The precipitous drop of hemoglobin in this case can be explained only by acute hemolysis since there was no evidence of blood loss. This is true even though no antibody was isolated. The circumstantial evidence of autohemagglutination and hyperglobulinemia immediately following lympholysis is strong.

### Comment

Whether the autoagglutination in this case is due to antigen-antibody binding or to some other process cannot be stated. The relationship of viremia to autoagglutination has been reported and reviewed.<sup>22</sup> Mechanisms for destruction of red cells by antibody with and without complement have also been investigated.<sup>23</sup> The clinical evolution of this case, telescoping events so that linkages can be observed, albeit not fully explicable, may add to a broader understanding of the relationships between antigens, antibody production, red-cell coating and red-cell destruction.

This case may also be considered an experimental model to be used in animal work. Viral-

induced lymphadenopathy treated with massive doses of steroids might harvest promptly a high-titer antibody for study. Further, it would be well to look carefully at antigenically stimulated patients with lymphadenopathy treated with steroids for a variety of clinical reasons. Less dramatic hemolysis and rise of cross-reacting antibody titers might otherwise escape detection.<sup>5</sup>

### Summary

A case has been presented in which apparent viral-induced lymphadenopathy and splenomegaly were acted upon by adrenocortical steroids. The result was massive lympholysis, release of lymphocytes as well as gamma globulin, coating of red cells and autohemagglutination, and marked hemolysis. The rapid telescoping of events depicted the relationship of intracellular immunoglobulin, intravascular globulin, red-cell agglutination, and hemolysis.

### Generic and Trade Names of Drugs

Demeclocycline hydrochloride — Declomycin (Lederle Laboratories)  
Hydrocortisone sodium succinate — Solu-Cortef (Upjohn Company)

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## Discussion of E.N.T. Case of the Month

(continued from p. 31)

This lesion has the typical appearance of a basal cell carcinoma of the lip. Note the pearly consistency of the tumor and its rolled edges. These are locally infiltrative tumors which rarely metastasize. The diagnosis should be confirmed by excisional or punch biopsy.

Small basal cell carcinomas may be successfully treated by a variety of methods. Surgical excision, radiation therapy, topical 5-fluorouracil paste, and cryotherapy all have been proven to be effective.

The patient pictured had excision of her lesion. Since these tumors have a tendency to extend beneath the intact adjacent skin, wide excision was necessary (Fig. 2). The defect produced was closed with a small flap elevated from her right cheek and rotated into the gap. The flap donor site

was then closed primarily, the scar falling into a normal skin crease (Fig. 3). Her postoperative appearance one year later is satisfactory (Fig. 4). There has been no recurrence of the tumor.



FIG. 3. Cheek flap has been transposed into the defect and donor site closed primarily.

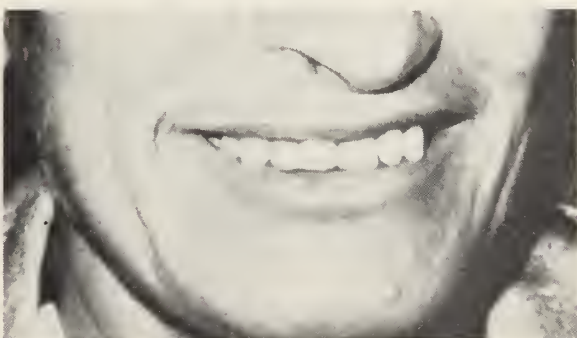


FIG. 4. Postoperative appearance one year after surgery.

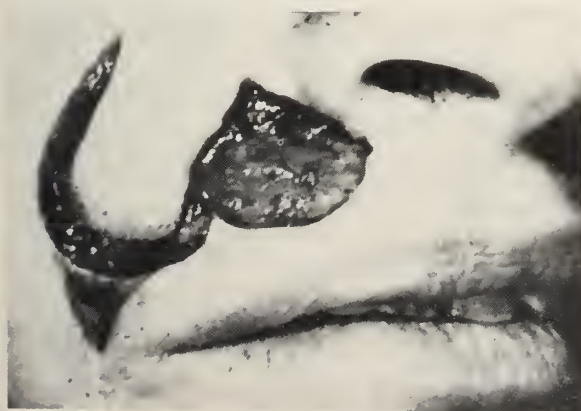


FIG. 2. Lesion has been excised with a wide margin of normal tissue. Note small cheek flap which has been elevated.

# Professional Activities



## Social Security Amendments of 1972 — A Summary of Provisions

This Is a Reader's Guide to Provisions in the New  
Federal Legislation Pertaining to Medicare, Medicaid, Maternal and  
Child Health, and Other Services Covered

ON OCTOBER 17, 1972, the House (305-1) and Senate (61-0) agreed to a compromise conference report on H.R. 1, the Social Security Amendments of 1972. The conferees, in their consideration of 583 Senate proposed amendments, deleted the Administration's Family Assistance Plan and also rejected a Senate-passed compromise welfare proposal which would have authorized experiments with alternative welfare systems.

The bill makes extensive changes in the Social Security program, as well as in Medicare, Medicaid, and Maternal and Child Health programs. Tax increases to finance these benefits were included, which now supersede tax increases enacted in June when Congress voted a 20 percent raise in retirement benefits which has now taken effect. Next year's social security tax rate will rise to a total of 5.85 percent of an individual's first \$10,800 income. The wage base would be increased again in 1974 to \$12,000. Likewise, the rate would rise to 6 percent in 1978.

Some 100 changes relating to Medicare, Medicaid, and Maternal and Child Health were

adopted in Title II of the bill. In capsule form, significant provisions include the following:

**Disability Beneficiaries**—Extension of Medicare to provide benefits for disabled persons receiving monthly cash benefits for at least 24 months under the Social Security or Railroad Retirement programs. Among those covered are: disabled workers; disabled widows and widowers between age 50 and 65; disabled persons 18 and older receiving social security benefits for disabilities occurring before age 22, and others. (Sec. 201)

**Uninsured Individuals**—Extension of Part A coverage under Medicare to individuals 65 and older, not otherwise eligible for Medicare, at a varying premium cost initially set at \$33 per month beginning in July 1973. Individuals electing to buy into Part A would be required to have Part B supplementary coverage. (Sec. 202)

**Part B Premium**—Fixing of Part B Medicare premium at \$5.80 per month through fiscal 1973, with any subsequent increases being related to the actuarial rate (one-half the estimated total benefit and administrative costs) or increases in monthly cash benefits. (Sec. 203)

**Part B Deductible**—Increase in the Part B Medicare deductible from \$50 to \$60 (Sec. 204)

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The text of this article was prepared by American  
Medical Association Staff Members.



**Automatic Enrollment**—Automatic enrollment in Part B, upon eligibility for Part A, for persons reaching 65 years of age after June 1973, unless an election is made not to participate in the supplementary program. (Sec. 206)

**Incentives under Medicaid**—Reduction in federal Medicaid matching for services in some facilities for lack of proper utilization and medical review methods: (a) by one-third after 60 days in a skilled nursing home or in an intermediate care facility, and (b) by one-third after 90 days (plus 30 days extension) in a mental hospital. . . No federal matching after a lifetime limit of 365 days in a mental hospital. . . Secretary given authority to compute reasonable cost differential for reimbursement between skilled nursing homes and ICF's. (Sec. 207)

**Cost-Sharing under Medicaid**—In States covering the medically indigent (those just above the income level for cash assistance), the medically indigent would be required to pay Medicaid premium, at graduated charges related to income. In addition, at State's option, the medically indigent could be required to pay deductibles and copayment amounts. Such deductibles and copayment need not be related to income level but must be nominal. (Sec. 208)

**Medicaid Eligibility for Certain Employed Families**—A welfare family losing eligibility for cash assistance because of increases in earnings remains eligible for Medicaid for a period of four months after cash assistance is stopped. States are not required to cover aged, blind, or disabled who are made newly eligible for assistance under the new federal increase in payment levels to such persons. (Sec. 209)

**Medicare Payment for FEHB Beneficiaries**—Beginning January 1, 1975, the Medicare program would not pay for any otherwise covered service if such service is covered under the Federal Employee Health Benefits plan in which the beneficiary to whom the service was provided is enrolled, unless certain conditions exist under which FEHB coverage is supplementary to Medicare benefits and certain contributions are made for the health insurance of such enrollees. (Sec. 210)

**Services Furnished Outside the U.S.**—Benefits are extended to cover services furnished a U.S. resident at a hospital outside the country if the foreign hospital is closer or more accessible from his residence; physician and ambulance services furnished in connection with such hospitalization; and emergency hospital services furnished in Canada to United States residents traveling between Alaska and the U.S. (Sec. 211)

**Optometrists' Services under Medicaid**—Where States which have previously covered op-

tometric services under Medicaid have retained specific coverage for eye care under physicians' services, then services of an optometrist also licensed to perform such services will be covered. (Sec. 212)

**Federal Participation for Capital Expenditures**—Authorization to withhold or reduce reimbursement amounts to providers of services and health maintenance organizations under Title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, related to certain expenditures that are determined to be inconsistent with state or local comprehensive health plans. (Sec. 221)

**Demonstrations re Prospective Reimbursement, etc.**—Requirement that the Secretary of HEW develop experiments and demonstration projects testing methods of making prospective payments under Medicare, Medicaid, and Maternal and Child Health Program, and to report on such projects to Congress by July 1, 1974. . . In addition, authorization to experiment with: (1) reimbursement to ambulatory surgical centers; (2) elimination of the 3-day hospitalization requirement for extended care benefits; (3) use of institutional and homemaker services as alternatives to post-hospital services; (4) provision of day care services; and (5) method of paying for the services of physicians' assistants under Medicare. . . also to study whether services of clinical psychologists may be made more generally available under Medicare and Medicaid. (Sec. 222)

**Limitations on Costs under Medicare**—Authorization to set prospective costs recognized as reasonable for certain classes of providers in various service areas, excluding costs of items or services in excess of, or more expensive than, those that are determined by the Secretary to be necessary in the efficient delivery of needed health services. Such excess costs could be charged directly to the beneficiary under certain conditions. (Sec. 223)

**Limits on Prevailing Charge Levels**—Limitation on reasonable charges, so as not to exceed the higher of the prevailing charge on December 31, 1970, or the prevailing charge level that, as determined by the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality in the base year preceding. In the case of physician services, limitations are placed on future increases, based on economic changes. Payments under the Medicaid and Child Health Programs could not exceed the limits established under the Medicare program for similar services. Where medical services, supplies, and equipment do not vary significantly between suppliers, the charges could not exceed lowest charge levels in the area . . . HIBAC to study

## Social Security Amendments of 1972 (Continued)

methods of reimbursement for physicians under Medicare to evaluate effects on physicians' fees generally, the extent of assignments accepted by physicians, and the share of total physician-fee costs which the beneficiary must assume. The Council is to make alternative recommendations to present methods and state a preferred method. (Sec. 224)

**Skilled Nursing Home and Intermediate Care Facility Payments**—Limitation on the average per diem cost for skilled nursing homes and intermediate care facilities countable for federal financial participation under Medicaid in any quarter to 105 percent of such costs for the fourth quarter of the preceding year, with allowable increases for added patient services. (Sec. 225)

**Payments to Health Maintenance Organizations**—Authorization for reimbursement, through a single capitation payment, to qualified HMO's making available directly or under other arrangements, such Part A and B services as would otherwise be available in the area. A qualified organization will have at least 25,000 members, of which not more than half are 65 or older, and will have been in operation at least two years (or, in a small or sparsely settled community, will have at least 5,000 members and be in operation at least three years). As incentives, the organization will be entitled to half of the savings represented by the difference between its costs and average per capita costs in the area for beneficiaries not enrolled in the organization, limited, however, to 10 percent of such average per capita costs. (Federal government would not share in losses.) The Secretary is directed to report annually to Congress on its experience with this provision. (Sec. 226)

**Teaching Physicians**—Reimbursement for services of teaching physicians to a nonprivate Medicare patient to be made under Part A on an actual cost or "equivalent cost" basis. Exceptions under which fee-for-service may continue, would include payments for Medicare beneficiaries who are bona fide "private patients," and beneficiaries in institutions which meet certain charging practices since 1965. (Sec. 227)

**Advance Approval of Extended Care and Home Health Coverage**—Authorization to the Secretary of HEW to establish, by medical conditions and length of stay or number of benefits, periods for which a patient would be presumed to be eligible for extended care or home health care benefits and services. (Sec. 228)

**Termination of Payments**—Authorization in the Secretary to terminate Medicare, Medicaid, and Maternal and Child Health repayments to

providers of health or medical services found guilty of fraudulent representation, excessive charges or furnishing services in excess of needs or of grossly inferior quality. The Secretary would create program review teams, in each state, composed of physicians, other professional personnel, and consumer representatives. (Sec. 229)

**Comprehensive Medicaid Programs**—Elimination of the requirement that each state broaden its scope of care and services under Medicaid and liberalize the eligibility requirements. (Sec. 230)

**Repeal of Section 1902(d) of Medicaid**—Repeal of Section 1902(d) of Medicaid, prohibiting States from reducing its expenditures for Medicaid from one year to the next. (Sec. 231)

**Reasonable Cost of Inpatient Hospital Services**—Authorization under Medicaid and Title V to the States to determine reasonable cost of inpatient hospital services in accordance with methods and standards developed by the State, but not to exceed reasonable costs under Medicare. (Sec. 232)

**Payments Where Reasonable Cost Exceeds Customary Charges**—Reimbursement for services by providers under Medicare, Medicaid, and Maternal and Child Health programs limited to the lesser of the reasonable cost of such services under Medicare, or the customary charges to the general public for such services, with special provisions applicable to a public provider furnishing services free or at nominal cost. (Sec. 233)

**Institutional Planning**—Requirement that institutional providers of services under Medicare have a written overall plan and budget reflecting an operating budget and a capital expenditures plan. (Sec. 234)

**Claims Processing and Information Retrieval Systems**—Federal matching funds under Medicaid for the cost of designing, developing and installing mechanized claims processing and information retrieval systems at a rate of 90 percent, and 75 percent for the operation of such systems, including any contracting for operating the system . . . Also funds for cost determination systems for state owned general hospitals. (Sec. 235)

**Prohibition Against Reassignment**—Reassignment of claims would be prohibited, thus limiting payment under Medicare and Medicaid generally to the patient, his physician, or other person providing the service, unless the physician or other person is required as a condition of employment to turn his fees over to his employer or unless he has an arrangement with the facility in which the services were provided under which the facility



bills for the services. (Direct payment could also be made to a foundation, association, plan, or contractor which provides and administers health care through an organized health care delivery system.) (Sec. 236)

**Utilization Review Requirements**—Requirement that hospitals and ECF's participating in Medicaid or Title V programs must have those patient cases reviewed by the same utilization review committee as is already reviewing their Medicare cases (or, if one does not exist, by a review group which meets Medicare standards). This requirement may be waived, however, where an alternate system has been approved by the Secretary. (Sec. 237)

**Unnecessary Admission**—Authority to the utilization committee to notify the physician, patient, and hospital that payment for services by Medicare will cease in three days in not only those cases where the Committee finds that hospital or extended care stay is no longer necessary, but also in cases where admission was not necessary. (Sec. 238)

**State Health Agency Functions**—Requirement that the state health agency (or other appropriate state medical agency) be the certifying agency within the state for health facilities for participation in the Medicare, Medicaid, and the Maternal and Child Health programs . . . Also required are state plans for the review of the appropriateness and quality of health care furnished under Title XIX and Title V. (Sec. 239)

**Medicaid and Comprehensive Health Care**—Permission to States to waive federal statewideness and comparability requirements if a state contracts with an organization which has agreed to provide health care and services in addition to those offered under the state plan to eligible people who reside in the geographic area served by such an organization and who elect to obtain such care and services from the organization. Payments could not be higher on a per capita basis than per capita payments for other Medicaid recipients in the same general geographic area who are not under the proposed arrangement. (Sec. 240)

**Qualifications for Certain Health Care Personnel**—A direction that the Secretary establish a program to determine the proficiency of health personnel who lack formal educational or professional membership requirements to perform their duties and functions. Persons then found qualified may provide services under Medicare and Medicaid. (Sec. 241)

**Penalties**—Among penalties under Medicare and Medicaid would be added: soliciting, offering, or accepting kickbacks or bribes, including a rebate for patient referral, and concealing or failing to

disclose knowledge of any event affecting a person's right to any benefit payment with the intent to defraud, or for converting benefits or payments to improper use. (Penalty: \$10,000 or imprisonment for up to one year.) Misrepresentation of health and safety conditions and operating conditions in health care facilities to qualify under Medicare and Medicaid would be subject to six months imprisonment, a \$2,000 fine, or both. (Sec. 242)

**Provider Reimbursement Review Board**—Establishment by the Secretary of a five-member Provider Reimbursement Review Board to hear appeals from final decisions of a fiscal intermediary, by a provider if the amount at issue is \$10,000 or more, or by a group of providers on a common cause if the amount at issue aggregates \$50,000 or more. Board decisions would be final unless Secretary on his own motion reversed or modified the decision adversely to the provider, in which case the provider will be entitled to court review. (Sec. 243)

**Validation of JCAH Surveys**—Authorization to the Secretary to enter into an agreement with any state under which the appropriate state or local certifying agency would survey JCAH accredited hospitals on a sample basis or, where the Secretary deems appropriate on the basis of substantial allegation of the existence of a condition significantly adverse to the health of patients. If the Secretary finds following a survey that an institution has significant deficiencies, then, after due notice, the institution could be disqualified as a Medicare provider, notwithstanding JCAH accreditation. (Sec. 244)

**Durable Medical Equipment**—Authorization to the Secretary to experiment with reimbursement approaches with respect to rental or purchase of durable medical equipment. (Sec. 245)

**Skilled Nursing Facilities**—Elimination of separate requirements and separate certification procedures under Medicare and Medicaid for skilled nursing facilities, and establishment of a single set of requirements. (Sec. 246)

**Skilled Nursing Home Services**—Establishment of a common definition of care requirements for extended care services under Medicare and skilled nursing services under Medicaid . . . Such services would be those provided directly by or requiring supervision of skilled nursing personnel which the patient needs on a daily basis and which as a practical matter could only be provided in a skilled nursing facility on an inpatient basis. (Sec. 247)

**Fourteen-Day Transfer Requirement**—Modification of the 14-day transfer requirement, to permit a patient to enter a skilled nursing facility



## Social Security Amendments of 1972 (Continued)

within 28 days after hospital discharge where the delayed admission occurred because of a shortage of appropriate bed space, or within such time as it would be medically appropriate to begin an active course of treatment for a condition not requiring such care within 14 days after discharge from a hospital. (Sec. 248)

**Reimbursement Rates for Skilled Nursing Homes and Intermediate Care Facilities**—Requirement that States reimburse skilled nursing and intermediate care facilities on a reasonable cost related basis by July 1, 1976, rising acceptable cost finding techniques approved and validated by the Secretary. (Sec. 249)

**Medicaid Certification and Approval of Skilled Nursing Facilities**—Determination of basic eligibility of skilled nursing home under Medicaid to be made by the Secretary, with appropriate state agency surveying facilities and reporting findings to the Secretary. A state could, for good cause, decline to accept as a participant in the Medicaid program a facility, even though certified by the Secretary. (Sec. 249A)

**Medicaid Compensation for Inspectors**—Beginning October 1, 1972, and ending June 30, 1974, the federal government will pay 100 percent of a state's costs of training and compensating personnel responsible for inspecting long-term care facilities to determine whether they comply with applicable Medicaid health and safety standards. (Sec. 249B)

**Disclosure of Performance Information**—Requirement that the Secretary make public the following evaluation and reports: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and state agencies, including the reports of followup reviews; (2) comparative evaluations of the performance of contractors; (3) program validation survey reports, with the names of individuals deleted. Public disclosure would not be required until the subject party was given suitable opportunity, not to exceed 60 days, to comment upon the findings and conclusions. (Sec. 249C)

**Limitation on Institutional Care**—Requirement that federal matching shall not be available for any portion of any payment by any State under Title I, X, XIV, or XVI, or part A of Title IV, of the Social Security Act for or on account of any medical or any other type of remedial care provided by an institution to any individual as an inpatient thereof, in the case of any State which has a plan approved under Title XIX of such Act, if such care is (or could be) provided under a State plan approved under Title XIX of such

Act by an institution certified under such Title XIX. (Sec. 249D)

**Eligibility for Medicaid of Social Security Beneficiaries**—For a limited period certain persons eligible for Medicaid will not become ineligible solely because of the increase in income resulting from the 20 percent increase in Social Security cash benefits. (Sec. 249E)

**Professional Standards Review Organizations**—Their purpose is to review locally-provided services covered by Medicare and Medicaid. PSRO's would determine that a given service was medically necessary, met professional standards, and (in cases of inpatient care) whether the patient might have been served more economically as an outpatient. Initially, PSRO's would be limited to review of health care provided in or by institutions, and could assume review of other services only with the approval of the Secretary of HEW. Through 1975, local physicians would be encouraged to organize to form PSRO's to serve their areas. A PSRO would be expected to represent a substantial proportion of local physicians. After 1975, the Secretary could, in certain circumstances, contract with other groups to perform the review job. (Sec. 249F)

**Physical Therapy**—Authorizes payment for physical therapy services performed in the therapist's office. (Sec. 251)

**Colostomy Supplies**—Coverage of certain supplies related to colostomies under Medicare. (Sec. 252)

**Medicaid Coverage Prior to Application**—Extension of coverage for Medicaid care and services furnished in or after the third month prior to an application by those individuals who were otherwise eligible when the services were received. (Sec. 255)

**Hospital Admissions for Dental Services**—Dentist certification of the necessity for inpatient hospital admission of his patient for dental services in those instances where the patient has other impairments so severe as to make hospitalization necessary. (Sec. 256)

**Prosthetic Lenses**—The definition of "physician" under Medicare would be modified so as to include optometrist, but only with respect to establishing the need for prosthetic lenses. (Sec. 264)

**Optional Medical Social Services-ECF**—Eliminates any requirement by extended care facility under Medicare to provide medical social services. (Sec. 265)

**Waiver of Registered Nurse Requirement**—

Authorization to Secretary to waive under certain conditions the requirement that a skilled nursing facility in a rural area must engage the services of a registered professional nurse for more than 40 hours a week. (Sec. 267)

**Requirements for Nursing Home Administrators**—Authorization to the State to grant a permanent waiver from Title 19 requirements for licensure to those individuals who served as nursing home administrators for the three-year period preceding the year the State established a licensure program. (Sec. 269)

**Increase in Medicaid Payments to Puerto Rico and the Virgin Islands**—Increases the total amount which the Secretary may certify for payment to Puerto Rico under Medicare for one year from \$20 million to \$30 million. Similarly increases Medicaid payment which may be made to the Virgin Islands from \$650,000 to \$1 million. (Sec. 271)

**Medical Assistance in Puerto Rico, the Virgin Islands, and Guam**—Delays from June 30, 1972, to June 30, 1975, the date at which "free choice" of institutional or other providers under Medicaid becomes effective for Puerto Rico, the Virgin Islands, and Guam. (Sec. 271A)

**Chiropractor Services under Medicare**—Extension of Medicare to include chiropractic services. Includes as a "physician" a chiropractor who is licensed as a chiropractor in his state (or is otherwise legally authorized by the state) and meets federal standards, but is included only for covered services limited to treatment by manual manipulation of the spine "to correct a subluxation demonstrated by x-ray to exist." (Sec. 273)

**Chiropractors' Services under Medicaid**—When included in the State plan, chiropractic services covered when furnished by a chiropractor who is licensed as such in the State and who also meets federal standards to be promulgated under Medicare. Covered services consist of treatment by means of manual manipulation of the spine. (Sec. 275)

**Services of Podiatric Residents and Interns**—Intern and residency program for podiatrists would be approved teaching programs under Part A of Medicare. (Sec. 276)

**Skilled Nursing Facilities**—Extended care facilities and skilled nursing homes redesignated as skilled nursing facilities for purposes of Medicare and Medicaid. (Sec. 278)

**Laboratory Billing of Patients**—Authorization to Secretary to negotiate a payment rate acceptable to laboratories for diagnostic tests, which payment will be considered as full charge for such tests. The negotiated rate would be limited to an

amount not to exceed the total payment which would have been made in the absence of such rate. (Sec. 279)

**"Physicians' Services" under Title XIX**—Definition of physician under the Medicaid program would be amended to specify the services of a duly licensed doctor of medicine or osteopathy as one of the mandatory items of health care services. (Sec. 280)

**Recovery of Incorrect Payments**—Presumption that any over-payment discovered after the expiration of three years will have been made without fault on the part of the provider and that no collection should be made . . . Additionally, the Secretary would be authorized to deny claims for reimbursement made after the lapse of a reasonable period of time of not less than one nor more than three years . . . Requirement that providers (or physicians or others where they have accepted assignments) where collection of an overpayment is made from the provider or others, be prohibited, after three years, from charging beneficiaries for services found to be medically unnecessary or custodial in nature, in the absence of fault on the part of the beneficiary. (Sec. 281)

**Conditions of Coverage of Outpatient Speech Pathology Services**—Coverage of outpatient speech pathology services under Part B to include speech therapy furnished to beneficiaries under the care of a physician by a provider of services, organized agencies, clinics, or health centers. (Sec. 283)

**Medical Assistance Advisory Council**—Elimination of the Medical Assistance Advisory Council. (Sec. 287)

**Health Insurance Benefits Advisory Council**—Modification of the role of HIBAC to provide advice and suggestions for the consideration of the Secretary on matters of general policy with respect to Medicare and Medicaid programs. (Sec. 288)

**Administrator of Social and Rehabilitation Service**—Requirement that new appointments to the office of Administrator of Social and Rehabilitation Service be made by President, with consent of the Senate. (Sec. 294)

**Repeal of Section 1903(b)(1)**—Deletion of maintenance of effort requirement for care of people 65 and over in mental hospitals under Medicaid program. (Sec. 295)

**Intermediate Care Furnished in Mental and Tuberculosis Institutions**—When a State chooses to cover individuals age 65 or over in institutions for tuberculosis or mental diseases it must cover such care in intermediate care facilities as well as in hospitals and skilled nursing homes. (Sec. 297)

**Independent Review of Intermediate Care Facility Patients**—Requires independent medical



Social Security Amendments of 1972 (Continued)

audit of Medicaid patients in all intermediate care facilities. (Sec. 298)

**Intermediate Care, Maintenance of Effort in Public Institutions**—A State or political subdivision responsible for the operation of a public institution for the mentally retarded under the Medicaid program will not be allowed to reduce services in such institution below the average amount expended in the four quarters preceding the quarter in which the state elected to make such services available. (Sec. 299)

**Treatment in Mental Hospitals for Individuals under Age 21**—Authorization of federal matching under Medicaid for eligible children under age 21 receiving inpatient care and treatment for mental diseases. (Sec. 299B)

**Survey Report Information**—Requires public disclosure of information concerning state surveys to determine compliance with statutory conditions of participation under Medicare and Medicaid by institutional providers, including health care facility, laboratory, clinic, agency or organization. (Sec. 299D)

**Family Planning Services Mandatory under Medicaid**—Federal funding of family planning services for present and former welfare recipients of child-bearing age and also for those persons likely to become welfare recipients in the absence of such services would be increased by authorizing 90 percent federal funding for state family planning programs. These programs would include

both counseling and the provision of medical and social services. A penalty of loss of 1 percent of AFDC matching will result where State fails to conform or supply recipients with requested family planning services. (Sec. 299E)

**Child Health Screening Services**—The federal share of AFDC matching funds will be reduced by 1 percent if a state in the prior year has failed to inform at least 95 percent of the AFDC families of the availability of health care screening, or has failed to provide for such services, or has failed to arrange for corrective treatment for children disclosed by such screening as suffering illness or impairment. (Sec. 299F)

**Chronic Renal Disease**—Disability status under SSA is provided to individuals who have not attained the age of 65, and are fully or currently insured under social security, or receiving cash benefits and their dependents, and who are medically determined to have chronic renal disease requiring hemodialysis or renal transplant. A qualified individual would be entitled to Medicare coverage after a waiting period following initiation of a course of renal dialysis. Eligibility would expire following a period after a kidney transplant or the termination of renal dialysis. (Sec. 299I)

**Elimination of Part B Coinsurance Payment for Home Health Services**—Part B of Medicare would be modified to provide reimbursement for 100 percent of the cost of home health services. (Sec. 299K)



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# Tentative Plans Show High Points of 1973 OSMA Annual Meeting

**T**HE 1973 Ohio State Medical Association Annual Meeting will center in the Sheraton-Columbus Motor Hotel and the Veterans Memorial Building, both in the downtown Columbus area. The meeting will start with the First Session of the House of Delegates on Sunday, May 6 and will be concluded on Wednesday afternoon, May 9.

Registration for members of the OSMA House of Delegates and for those attending the First Session will open at 3:00 p.m. on Sunday, May 6, in the Sheraton-Columbus Hotel.

Councilor District Caucus meetings will be held in Studio Rooms of the Councilors.

A buffet dinner for those attending the House of Delegates in an official capacity, or as guests, will be served at 5:30 p.m. Sunday at the hotel. The business session will get underway at 7:00 p.m.

Reference Committee Hearings will start at 8:30 a.m. on Monday, May 7 in rooms designated in the program. Hearings will continue on Monday afternoon.

All members of the Association are invited to attend sessions of the House of Delegates, but the privilege of the floor is customarily reserved for those attending in an official capacity. OSMA members are invited to participate in discussions at Reference Committee hearings.

The Final Session of the House will be held on Wednesday, May 9, beginning at 3:30 p.m., with a buffet dinner following the session.

Scientific program features begin with a General Session on Monday, May 7 at 9:00 a.m. at the Veterans Memorial Building. General registration opens at 8:30 a.m. at the Veterans Building.

Exhibits also open at 9:00 a.m. on Monday in the Veterans Memorial Building. Included will be Technical exhibits presented by pharmaceutical and other suppliers of products and services, health-education exhibits, and scientific exhibits. Traditionally the OSMA presents excellent exhibits in all of these fields. Exhibits will be open 9:00 a.m. to 4:30 p.m. on Monday and Tuesday, and from 9:00 a.m. to 3:00 p.m. on Wednesday.

Listed in the following columns are features in outline form as scheduled before this issue went to press. Watch for more details in coming issues of *The Journal*.

## Sunday, May 6

- 3:00 p.m. Registration for OSMA House of Delegates, Sheraton-Columbus Hotel
- 4:00 Councilor District Caucuses
- 5:30 Buffet Dinner for those attending the House of Delegates, Sheraton-Columbus
- 7:00 House of Delegates, First Business Session

## Monday, May 7

- 8:30 a.m. Reference Committee Hearings open, Columbus-Sheraton
- 8:30 General and Advance Registration opens, Veterans Memorial
- 9:00 All Exhibits open
- 9:00 General Session, "Sexual Counseling," Veterans Memorial
- 11:00 Health Commissioners Institute opens, Veterans Memorial
- 2:00 p.m. Continuation of "Sexual Counseling" session
- 5:00 Reception for exhibitors, Sheraton-Columbus

## Tuesday, May 8

- 7:30 a.m. Four Continuing Medical Education Courses (Subjects to be announced), Sheraton-Columbus; fee of \$10 per person per course.
- 8:00 OMPAC Board Breakfast, Sheraton-Columbus
- 9:00 Exhibits open, Veterans Memorial
- 9:00 Combined Program, Chest Physicians and Ohio Thoracic Surgeons, Veterans Memorial
- 9:00 Health Commissioners Institute continues, Vets Memorial
- 9:00 Section on Sports Medicine, Vets Memorial
- 9:00 Section on General Practice—"Doctor, I Have a Question for You," Vets Memorial

*(Continued on Page 57)*

# MAKE YOUR HOTEL RESERVATIONS For The 1973 OSMA Annual Meeting COLUMBUS, OHIO

**MAY 6-9**

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## SHERATON-COLUMBUS MOTOR HOTEL

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(Name of Hotel)

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Columbus, Ohio

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 6-9, 1973 (or for period indicated).

\_\_\_\_\_ Single Room \_\_\_\_\_ Twin Room  
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Arrival: May \_\_\_\_\_ at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Departure: May \_\_\_\_\_ at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

**PLEASE VERIFY MY RESERVATION**

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Address \_\_\_\_\_

## Annual Meeting Schedule (Contd.)

9:00 Section on Pathology, Vets Memorial  
 9:00 General Session (panel program), Sponsored by Ohio Society of Internal Medicine, OSMA Section on Internal Medicine, Vets Memorial  
 11:30 OMPAC Luncheon, Sheraton-Columbus  
 11:30 Luncheon, Colon and Rectal Diseases, Sheraton-Columbus  
 12:30 p.m. Luncheon, Sports Medicine, Sheraton-Columbus  
 1:00 Section on Pathology, Vets Memorial  
 1:30 Section on Neurology, Vets Memorial  
 1:30 Health Commissioners Institute continued  
 2:00 Combined Program, Chest Physicians and Ohio Thoracic Surgeons, continued, Vets Memorial  
 2:00 Section on Colon and Rectal Diseases, Vets Memorial  
 2:00 "Things You Always Wanted to Know, but Were Afraid to Ask," panel program presented by physicians for medical assistants, secretaries, nurses, technicians, bookkeepers, receptionists, etc., Vets Memorial  
 3:00 Section on Anesthesiology, Vets Memorial  
 6:30 Scioto Downs Party, OSMA Social Function  
 Watch for details on this night at the races

### Wednesday, May 9

7:30 a.m. Four Continuing Medical Education Courses (continuation of Tuesday morning program), Sheraton-Columbus; \$10 registration fee  
 7:30 Breakfast and Business Meeting, Ohio Committee on Trauma, American College of Surgeons, Sheraton-Columbus  
 8:00 Breakfast, Board of Governors, Ohio Ophthalmological Society  
 8:30 General and Advance Registration opens, Vets Memorial  
 9:00 Exhibits open, Vets Memorial  
 9:00 Section on ENT and Ohio Society of Ear, Nose and Throat, Vets Memorial

9:00 Health Commissioners Institute continues, Vets Memorial  
 9:00 Program sponsored by Section and Ohio Neurosurgical Society, OSU Medical Center  
 9:00 Program sponsored by the Ohio Affiliate, American Heart Association, Vets Memorial  
 9:30 General Session: "A Day in the Emergency Department," Ohio Committee on Trauma, ACS, Section on Occupational Medicine, and Section on Plastic Surgery, Vets Memorial  
 10:00 Ohio Ophthalmological Society Business Meeting  
 12:00 noon Luncheon, Section and Ohio Neurosurgical Society  
 12:00 Luncheon, Section on Rheumatology, Sheraton-Columbus  
 12:00 Luncheon and Critique, Committee on Scientific Work, Sheraton-Columbus  
 12:30 p.m. Luncheon, ENT, Sheraton-Columbus  
 1:30 Health Commissioners Institute continues, Vets Memorial  
 2:00 "A Day in the Emergency Department," program continues, Vets Memorial  
 2:00 Program sponsored by Section and Ohio Neurosurgical Society continues, Vets Memorial  
 2:00 Section on ENT and Ohio Society of Ear, Nose and Throat, continued, Vets Memorial  
 2:00 Combined program presented by Radiology and Rheumatology Sections, Vets Memorial  
 2:00 Sections on Directors of Medical Education, Business Meeting, Vets Memorial  
 2:30 Registration for House of Delegates, Sheraton-Columbus  
 3:00 Program presented by Section on Ophthalmology and Ohio Society of Ophthalmologists, Vets Memorial  
 3:00 Exhibits close  
 3:30 Final Session, OSMA House of Delegates  
 Buffet dinner for those attending the House of Delegates in official capacity following the Final Session.





## 1973 Annual Meeting, Ohio State Medical Association

**DO YOU HAVE AN EXHIBIT** or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1973 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be Monday through Wednesday, May 7, 8 and 9.

Mail applications to the attention of Jerry J. Campbell, Exhibit Manager, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

### APPLICATION FOR SPACE SCIENTIFIC EXHIBITS

## 1973 Annual Meeting, Ohio State Medical Association

**Veterans Memorial Building, Columbus, May 7, 8 and 9**

1. Title of Exhibit: \_\_\_\_\_
2. Name(s) of Exhibitor(s): \_\_\_\_\_  
Institution (If desired): \_\_\_\_\_  
City \_\_\_\_\_
3. Do you have a built-in exhibit? \_\_\_\_\_
4. Booth Requirements: Back wall \_\_\_\_\_ All side walls are 6' deep  
(indicate footage)
5. Description of Exhibit: (Attach 200 word description to this blank)

**Deadline For Filing Applications, February 1, 1973**



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including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and GI tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug. **Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult GI. bleeding with anemia, gastritis,

epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult GI. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement (B)98-146-070-G

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# Continuing Education Opportunities for Physicians in Ohio

**Surgical Seminars** — Medical College of Ohio at Toledo and Northwestern Ohio Institute for Continuing Medical Education; one hour a day, one day a week, for 88 weeks; dates on request.

**Clinical Days on Emergency Care** — 80 hours of instruction on 20 separate days, September to June; Medical College of Ohio at Toledo, 945 S. Detroit Ave., Toledo 43614.

**Introductory Course in Nuclear Medicine for Physicians** — Nuclear Medicine Institute, 6760 Mayfield Rd., Cleveland 44124; five-day courses; dates upon request.

## January

**Association of Physicians of the State of Ohio** — Quarterly meeting and program, January 12 at the Mt. Vernon State Hospital; contact Virginia S. Edwards, M.D., Secretary, 347 Lexington Ave., Mansfield 44907.

**Managing the Complicated Surgical Patient** — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; January 17-18.

**Movement Disorders** — Youngstown Hospital Association, South Unit, January 18, 8:00 a.m.; Dr. Harold Mars, clinical instructor in neurology, Case Western Reserve University.

**Medical Aspects of Drug Addiction in Dayton** — Veterans Administration Center, 4100 W. Third St., Dayton 45428; January 19, 2:30 to 4:30 p.m.; presentation by Barrett H. Bolton, M.D., director of education, Department of Internal Medicine, Miami Valley Hospital, Dayton; contact Hassan Mehbod, M.D., at the center.

**Treatment of Diseases of the Esophagus** — University of Cincinnati College of Medicine, January 25; contact Office of CONMED, 114 Medical College Building, Cincinnati 45219.

**Acute Airway Obstruction** — Youngstown Hospital Association, South Unit, January 27, 9:00 a.m.; Division of Surgery Guest Professor W. H. Maloney, M.D., Cleveland.

**Gastroenterology** — Ohio State University College of Medicine, January 31; contact Center for Continuing Education, 320 W. Tenth Ave., Columbus 43210.

**Medical Progress for the Family Physician** — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; January 31- February 1.

## February

**Ohio State University College of Medicine, Continuing Medical Education Conferences**; for details contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210:

**Advanced Rhinoplasty** — February 5-7 (Hawaii)

**Infectious Diseases** — February 7, Center for Tomorrow

**ENT Conference** — February 15, Stouffer's University Inn

**Group Psychotherapy** — Fridays, February 16 through May 4, Center for Tomorrow

**Electromyography XII** — February 19-22, Dodd Hall and Stouffer's Inn

**Orthopaedic Problems** — February 21, Center for Tomorrow

**Cleveland Clinic Educational Foundation:**

**Drugs and Treatment Techniques in Angiograph**, February 7-8

**Pharmacology and Clinical Effectiveness of Anti-inflammatory Drugs**, February 21-22

**Sports Medicine**, February 28-March 1

**Fifth Annual Infectious Disease Conference** — Office of Continuing Education (CONMED) of the University of Cincinnati, at the center, February 23.

*(Continued on Page 64)*



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SYNTHROID® (sodium levothyroxine) is pure synthetic T<sub>4</sub>, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T<sub>3</sub> is more fickle. Sometimes it binds. Sometimes it doesn't. T<sub>4</sub> more predictably binds to protein.

No calculations are needed, test interpretation is simple.

Any of the commonly used T<sub>4</sub> thyroid function tests (P.B.I., T<sub>4</sub> By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T<sub>4</sub> because they all measure T<sub>4</sub>. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

(1) The onset of action of T<sub>4</sub> is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)<sup>1</sup>; (2) since SYNTHROID contains only T<sub>4</sub>, the potential for metabolic surges traceable to more potent iodides (T<sub>3</sub>) is eliminated.

| TEST                      | HYPOTHYROID               | SYNTHROID THERAPEUTIC NORMAL |
|---------------------------|---------------------------|------------------------------|
| P.B.I.                    | Less than 4 mcg %         | 6-10 mcg %                   |
| T <sub>4</sub> By Column  | Less than 3 mcg %         | 7-9 mcg %                    |
| T <sub>3</sub> (Resin)    | Less than 25%             | 27-35%                       |
| T <sub>3</sub> (Red Cell) | Less than 11%             | 11.5-18%                     |
| Free Thyroxine            | Less than 0.7 nanograms % | 0.7-2.5 nanograms %          |
| Murphy-Pattee             | Less than 2.9 mcg %       | 4-11 mcg %                   |



**AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.**

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Read the accompanying prescribing information for additional data or write Flint Laboratories.

**Choose the Smooth Road ...to thyroid replacement therapy**





PATIENTS CAN BE SUCCESSFULLY MAINTAINED ON A DRUG CONTAINING THYROXINE ALONE.

Thyroxine ( $T_4$ ) is, as you know, the major circulating hormone produced by the thyroid gland.  $T_3$  is also produced, in smaller amounts, and is active at the cellular level. For years it has been a working hypothesis among endocrinologists that  $T_4$  is converted by the body to  $T_3$ . In 1970 this process, called "deiodination," was demonstrated by Braverman, Ingbar, and Sterling<sup>2</sup>.  $T_4$  does convert to  $T_3$ , though the precise quantities are still being studied.

The conversion has been clinically demonstrated during the administration of  $T_4$  to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, yet the presence of  $T_3$  in these patients has been clearly shown.

# Synthroid<sup>®</sup>

(sodium levothyroxine)

THE FACTS ARE CLEAR AND HERE IS OUR OFFER.

#### FACTS:

Synthetic thyroid drugs are an improvement over animal gland products. Patients, even athyrotic ones, can be completely maintained on SYNTHROID ( $T_4$ ) alone. Thyroid function tests are easy to interpret since they are predictably elevated when the patient adheres to SYNTHROID. Of all synthetic thyroid drugs, SYNTHROID is the most economical to the patient.



## WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING $T_3$ ?

Very simple.  $T_3$  costs more to make synthetically than does  $T_4$ . So it is economically necessary for a synthetic thyroid medication containing  $T_3$  to cost more than one containing  $T_4$  alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID<sup>3</sup> because the  $T_3$  costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine ( $T_4$ ) to Triiodothyronine ( $T_3$ ) in Athyrotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

#### OFFER:

Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for Injection is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.



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## Educational Opportunities in Ohio — *Continued*

**Arrhythmias**—Youngstown Hospital Association, South Unit, February 26, 4:00 p.m.; Drs. A. V. Whittaker and C. G. Battistelli.

**Sixth Ohio Intercontinental Conference on Diagnostic Medicine** — Ohio Academy of Family Physicians; 24 hours of instruction, February 26 through March 11.

### March

**Studies on the Regulation of Sodium Balance** — Veterans Administration Center, 4100 W. Third Street, Dayton 45428, March 2, 2:30 to 4:30 p.m.; lecturer, Jay H. Stein, M.D., Gustav Hirsch Professor of Medicine, at Ohio State; contact, Hassan Mehdob, M.D., at the center.

**Fourth Biannual Short Course on Laser Safety** — Sponsored by the Medical Laser Laboratory and the Office of Continuing Medical Education (CONMED) of the University of Cincinnati, March 5-9, at the University; contact Laser Safety Course, CONMED, 114 Medical College, Cincinnati 45219; tuition, \$325.

**Ohio State University College of Medicine, Continuing Medical Education Conferences**; for details contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210:

**Ophthalmology Conference** — March 5-6, Center for Tomorrow

**Neurochemistry** — March 12-15, Center for Tomorrow

**Neurology Conference** — March 18, Center for Tomorrow

**Pediatrics Clinic Day**, March 21, at Children's Hospital, Columbus

**Dermatology and Allergy** — March 28, Center for Tomorrow

**General Practice Seminar** — March 31-April 1, Center for Tomorrow

**Cleveland Clinic Educational Foundation:**

**Medical Progress and Its Relationship to Dentistry**, March 7-8

**Advances in Urology**, March 14-15

**Hodgkins Disease, Leukemia and Lymphoma**, March 21-22

**Treatment of Neurological Diseases**, March 28-29

**Eighth Annual Cancer Symposium** — Akron City Hospital, 525 E. Market Street, Akron 44309; March 14-15.

**Cincinnati VA Hospital Annual Seminar** — March 15, at the hospital, 3200 Vine Street, Cincinnati 45220.

**Low Renin Hypertension**—Youngstown Hospital Association, South Unit, March 15, 8:00 a.m.; Dr. Randall H. Travis, assistant clinical professor of medicine, Case Western Reserve University.

**Upper Respiratory Infections and Related Diseases**—Youngstown Hospital Association, South Unit, March 26, 4:00 p.m.; Medical Seminar; Drs. R. J. Smith and R. Hoffler.

**Treatment in Psychiatry—Theory and Practice** — at the VA Hospital, 1000 Brecksville Rd., Cleveland 44141; cosponsored by the Northwestern Ohio Institute for Continuing Medical Education and the Medical College of Ohio at Toledo; 49 hours, March 26-30.

### April

**Ohio State University College of Medicine, Continuing Medical Education Conferences**; for details, contact OSU Center for Continuing Medical Education, 410 W. 10th Ave., Columbus 43210:

**Cancer Symposium**, April 4

**Lederle Conference**, April 8

**Sex and Spinal Cord Injuries**, April 12-13

**Plastic Surgery in General Practice**, April 25

**Anesthesia**, April 27

**Myelomeningocele Conference**, April 28-29

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106;

**Current Topics in Clinical Microbiology**, April 4-5

**Peripheral Vascular Disease**, April 25-26

**Orthopaedic Surgery**, April 11-12

**To Bypass or Not to Bypass**—Youngstown Hospital Association, South Unit, April 9, 4:00 p.m.; Medical Seminar; Drs. J. L. Calvin and R. A. Weiss.

**Chronic Glomerular Disease: Clinical Pathological Correlations and Indications for Treatment**—Youngstown Hospital Association, South Unit, April 19; 8:00 a.m.; Dr. Robert S. Post, associate professor of medicine, Case Western Reserve University.

**Clinical and Laboratory Estimation of Renal Function**—Youngstown Hospital Association, South Unit, April 23, 4:00 p.m.; Medical Seminar; Drs. R. A. Bacani and Y. O. Sheth.

# Obituaries

**Donald Murphy Blizzard, M.D.**, Middletown; Ohio State University College of Medicine, 1916; aged 79; died November 2; member of OSMA and AMA; retired in recent years after practicing in the Middletown area from 1921 to 1965; veteran of World War I; past president of the Butler County Medical Society.

**Gerhard H. W. Bruggemann, M.D.**, Fostoria; Medical College of South Carolina, 1927; aged 69; died November 20; member of OSMA, AMA, and American Academy of Family Physicians; practicing physician in the Fostoria area for 35 years. Two sons are Dr. William G. Bruggemann, of Toledo, and Dr. George E. Bruggemann, of Dayton.

**Forder Franklin DeMuth, M.D.**, Hicksville; Ohio State University College of Medicine, 1935; aged 65; died November 26; member of OSMA and AMA; general practitioner for 35 years in the Defiance County community.

**Joseph M. Hertzberg, M.D.**, Toledo; Ohio State University College of Medicine, 1934; aged 69; died November 17; member of OSMA, AMA, and the American Society of Abdominal Surgeons; lifelong resident of Toledo, and practitioner there since 1934, specializing in obstetrics and gynecology; veteran of World War II.

**Gerald Martin Johnston, M.D.**, Toledo; Meharry Medical College School of Medicine, 1923; aged 80; died November 14; general practitioner in Shreveport, La., for 20 years and in Toledo from 1943 to 1967.

**William Lawrence Mahaffey, M.D.**, Oakland, Calif.; Ohio State University College of Medicine, 1933; aged 66; died November 8; former member of OSMA; general practitioner in Fredericktown from 1936 to 1960 when he moved to California. A daughter, Dr. Marilyn M. Pollak, is a radiologist in the Oakland area.

**Paul Kuch Morse, M.D.**, Cincinnati; Eclectic Medical College, Cincinnati, 1927; aged 70; died October 20; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner of long standing in Cincinnati.

**Atlee Ross Olmstead, M.D.**, Lake Worth, Fla.; Ohio State University College of Medicine, 1911; aged 84; died November 2; member of OSMA and AMA; practitioner in Canton for many years before his retirement; veteran of World War I.

**Wilbur Samuel Powell, M.D.**, Georgetown; Eclectic Medical College, Cincinnati, 1921; aged 83; died November 18; former member of OSMA; practitioner in Dayton for about 30 years before his retirement in the 1940's.

**Linus Edwin Rausch, M.D.**, Kettering and Dayton; University of Cincinnati College of Medicine, 1940; aged 59; died October 29; member of OSMA, AMA, and American Society of Internal Medicine; Fellow, American College of Physicians; diplomate, American Board of Internal Medicine; practitioner in the Dayton area since 1943; former president of the Dayton Society of Internal Medicine and of the local Heart Associa-



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tion; former trustee of the Montgomery County Medical Society.

**Richard Allen Stamm, M.D., Norwalk, Conn.;** Ohio State University College of Medicine, 1955; aged 45; died November 17 at the hand of assailants while making a professional call in a low income area; left Ohio after taking his internship in Cleveland and later set up psychiatric practice in the Connecticut community.

**Edward Robert Thomas, Sr., M.D., Dayton;** University of Cincinnati College of Medicine, 1931; aged 68; died November 26; member of OSMA, AMA, American Academy of Ophthalmology & Otolaryngology, and the Association for Research in Ophthalmology; Fellow, American

College of Surgeons; diplomate, American Board of Ophthalmology; practicing ophthalmologist in the Dayton area since the early 1930's; member of the OSMA Committee on Eye Care. Dr. Edward R. Thomas, Jr., is a practicing physician in Dayton and was in association with his father.

## Provisions in OSMA Bylaws Pertaining to Nomination of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 6-9.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal*, unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 7.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect."

"Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon the filing of such candidate's name, the Executive Director shall prepare and transmit this information to each member of the House of Delegates. No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal."

## Deadline for Submission of Resolutions to OSMA Office is March 7

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1973 Annual Meeting should be guided by Chapter 4, Section 8 of the OSMA Bylaws entitled "Resolutions."

"Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates."



# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dornan Drive, Portsmouth 45662

HOPEFULLY I'm not the only one who feels that the year 1972 swooshed by with hurricane force! Somehow, it just doesn't seem possible that it has come—and gone. And that 1973 stares up at us from the calendar . . . Welcome to you, then, this New Year, and let me say it in the words of Alfred Lord Tennyson (even if poetry is the last thing one would expect to find in this column!):

"Ring out the old, ring in the new, ring happy bells across the snow; ring in the nobler modes of life, with sweeter manners, purer laws; ring out the shapes of foul disease, ring out the narrowing lust of gold; ring out the thousand wars of old, ring in the thousand years of peace; ring in the valiant man and free, the larger heart, the kindlier hand—ring out the darkness of the land . . ."

Doctors' wives have an important stake in the New Year because, in their own way, they can do so much to help make it a better year—not in any miraculous fashion, to be sure. But that timeworn "every little bit helps" still holds fast. Should we not resolve, then, to reflect and enrich the doctor's dedicated service by furthering the work and the spirit of our Auxiliary which was founded for that very purpose?

## Follow-Up

"Book a Speaker" brochures are the latest follow-up to the Speakers' Bureau activity that was described in the November issue of *The Jour-*

*nal*. This is the work of Mrs. Christopher A. Colombi, chairman of the Program Extension Committee and "architect" of the new venture in cooperation with the Ohio State Medical Association.

"Join the IN group," advises the pamphlet. "INvaluable INformation of INTERest by INFORMED speakers . . . Your group can be IN the know IN the medical and health care field." Each county auxiliary has been supplied with large quantities of the brochure for distribution to local PTA's, church groups, civic groups, educational groups and so on. Twenty-two talk subjects are listed covering a wide field in the medical and health care picture, from which a group may choose a particular subject or subjects of special interest.

In a recent communication to county auxiliaries, Mrs. Colombi said: "We would like you to (1) obtain approval of your Medical Society advisor, (2) circulate the brochures to PTA's, church groups, civic groups and other lay organizations, (3) fill in the name of local contact from local auxiliary on back of brochure, (4) add any comments local auxiliary wishes to make to prospective audiences on back page—and then—contact Mrs. Colombi in care of Central Office if a speaker is needed; list group and number in audience if a member of your auxiliary speaks to any group (auxiliary or lay) and send to Central Office; and consider this project as one of 'con-

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## THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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### President

Mrs. Louis Loria  
Box 331, R. D. 1  
Bristolville, 44402

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313 Rumson Dr.  
Englewood, 45322

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Columbus, 43209

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Salem, 44460

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3405 Kappel Dr.  
Springfield, 45503

### Treasurer

Mrs. Paul Hahn  
122 Moore Ave.  
New Philadelphia, 44663

## Auxilians Participate in Speakers Seminar



Robert A. Lang, Ph.D., Executive Secretary, Academy of Medicine of Greater Cleveland, is shown conducting a two-day speakers training seminar for leaders of the Woman's Auxiliary to the Ohio State Medical Association. The Seminar was held in Columbus September 21-22 under sponsorship of OSMA.



Principals in the speakers training seminar sponsored by the Ohio State Medical Association for leaders of the Woman's Auxiliary are shown reviewing the successes of the fall meeting. Shown are (seated, left to right, Robert A. Lang, Ph.D., Executive Secretary, Academy of Medicine of Greater Cleveland, and Mrs. C. A. Columbi, Cleveland, chairman of the Auxiliary's Program Development Committee, (standing, left to right) Alexander Lagusch, Assistant Executive Secretary of the Cleveland Academy and one of the seminar instructors, and Mrs. Louis A. Loria, Bristolville, President of the Woman's Auxiliary. The seminar was designed to develop a program whereby Auxiliary members taking the course could become informed, effective public speakers.



tinuity' since bookings can be made even for the Spring of the coming year."

The Speakers' Bureau can be an effective health education arm and a very worthwhile community effort on the part of our county auxiliaries. The Ohio State Medical Association has a big investment in this. Now it's up to us to produce those dividends in community service!

### "LEGS"

Last month's column had a special message from Mrs. S. B. Pfahl, state legislation chairman. Mention was made of the package program called "Legislative Effort Group System", or as it is more popularly called "LEGS." I'd like to present now more of a detailed picture of this newer and very important auxiliary activity.

First and foremost, according to Mrs. Pfahl, is the keeping of every doctor's wife knowledgeable about the governmental process and what projects and activities are important to support organized medicine. The program is designed to strengthen the relationship of the auxiliaries to the medical associations on the national, state, and local levels. Says Mrs. Pfahl: "Doctors' wives must be knowledgeable on the mechanics of Government operation, Federal legislation, political education and activity, as well as public relations."

In listing the activities to be used by local legislation chairmen, emphasis is placed on the importance of clearing, first, such activities with the county and/or state medical society. Here are some of the suggested activities: Conducting a letter writing campaign; preparation of informational programs on state and national medical

and health care legislation, political education and political activity for presentation at auxiliary meetings, workshops and conferences; including news reports in auxiliary newsletters and editorials in state and county medical society journals; encouraging individual and group attendance at public hearings, especially when medical and health care issues are to be discussed; entertaining group parties when medical and health related topics are to be discussed on radio and television, or when a political candidate is available for a personal visit or when he or she is making a radio or television appearance; making telephone calls to "Question and Answer" radio and television programs to insure that organized medicine's position is heard; acting as a clipping service during local, state and national elections, as well as for all medical and health care issues.

The "LEGS" communication system—a telephone "alert" system—has been dubbed "LEGS-LINE." It can be used to communicate any of the important suggestions as outlined in the preceding paragraph. Mrs. Pfahl advises me that the "Legs-line" communication system is in the process of detailed development in cooperation with OSMA. If you'd like more information on this, write Mrs. S. B. Pfahl, 416 Newport-Huron-44839.

### Here and There

"Butler Billboard" is the name of the chatty, interesting and informative newsletter put out by the **Butler County** auxiliary and its president, Mrs. William J. Crawford. The September issue highlighted the luncheon at the Carusel Inn in Cincinnati and the special candle and "arrangements"

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demonstration. There was an excellent "pitch" for the sale of Christmas cards for the benefit of AMA-ERF. (Butler won the state's AMA-ERF award at the 1972 convention for the largest increase.) And this year's Christmas card for AMA-ERF has netted a whopping \$3,104.00! (Butler's own Joan Rothermel is the talented artist for this 1972 card.)

One of the group's Health Careers Day was held in Hamilton on November 3, with approximately 250 in attendance. Another Health Careers Day was held in Middletown on November 14. There approximately 275 attended. Mrs. Henry Floyd chaired the Hamilton activity and Mrs. William Neel, the Middletown activity. Butler's president, Mrs. Crawford, tells me that Mrs. Neel has served as chairman of the Middletown Health Careers Day for the 11 years of its existence! (in cooperation with Middletown Hospital). An orchid to Mrs. Neel!

On Sunday, November 5, the *Middletown Journal* ran a feature story on auxiliary member Mrs. Ross Hill who is in her "70-plus years." She is a charter member of the Butler auxiliary who, for many years, has traditionally installed the newly elected officers of the group. She still comes to meetings when she is able, although her health has not permitted her to be as active as she has been in the past. The newspaper story on Mrs. Hill was a warm and vivid word-picture of an extraordinary and talented doctor's wife. The feature's headline summed it all up neatly: "Mrs. Hill's Too Busy To Spend Post-70's in a Rocking Chair" . . . . .

### Cincinnati and the AMA

The Hamilton County auxiliary is not likely to forget the year 1972 in a hurry! For it was the year of two conventions in Cincinnati—and the serving as the hostess auxiliary for both. There was the state convention in May—and then the very recent AMA Clinical Convention November 26-29. The Hamilton County members did a superb job both times. . . . .

Over 500 attended the Montgomery County Glee Club concert on Sunday evening, the 26th, in the Cincinnati Exposition Center. Proceeds from the musical event have been turned over to AMA-ERF.

And then there was the fascinating Shaker-town trip at Pleasant Hill, Kentucky. The demand for tickets was so great that all local members had to turn in their tickets so that the out-of-town women could go! Even then, many had to be turned away. This trip included an excellent luncheon at the Old Trustees' House at Shakertown.

Tuesday's luncheon at the Netherland-Hilton was another tremendous success, and once again many had to be turned away for lack of space.

However, Standing Room Only was permitted for the demonstration of that well-known gourmet chef, Peter Glabnitz, and his display of "Holiday Fare." Additional events included a walking tour of Mt. Adams and an "antiquing tour" and luncheon at Lebanon.

And I mustn't forget mention of the watch sale that was a complete sell-out! The Hamilton group (as do many other auxiliary groups) sell these very special and beautiful watches for the benefit of AMA-ERF. I am told by Mrs. Robert G. Slagle, Hamilton's publicity chairman, that not a single watch of the local group's supply was left unsold! How's that for doing business for AMA-ERF??

Here's just a quick "preview" of the auxiliary's "Golden Ball" that was held on December 2 at the new Riverview Inn in Covington, Kentucky. The designation "Golden Ball" was to commemorate the golden anniversary of the National Auxiliary. (Hopefully, more on this next month.)

### Down Scioto-Way

Doctors' wives from Columbus, Lancaster, Greenfield and Chillicothe were present at a luncheon meeting of District 9 held in Portsmouth late in October, with the Scioto County group serving as hostess. Mrs. B. U. Howland, district director, presided at the afternoon session which followed a luncheon at Harold's Restaurant.

Talks were given by Mrs. Armin A. Melior, state director-at-large and state chairman of health education; and Mrs. Samuel L. Meltzer, past state president and state publicity chairman. The guests were welcomed by Mrs. David Livingston, Scioto president. Piano music was provided by Miss Melba Miller.

For the program, Mrs. Eleanor Berry of Ashland, Kentucky, presented "The Look of Fashion and the Art of Fashion Know-How To-day." Fall flowers, leaves and cornucopia arranged by Mrs. Ralph A. Herms decorated the luncheon tables. Hostesses were Mrs. Herms, Mrs. Ralph W. Lewis, Mrs. Miller F. Tooms, Mrs. Howland, Mrs. Alden B. Oakes, Mrs. Manuel Pezeshki and Mrs. Livingston. That evening, members attended a dinner-meeting sponsored by the Scioto County Medical Society in conjunction with its day-long Medical Seminar.

### An Invocation

Some two years ago, Mrs. Robert Colopy of Painesville gave the invocation at the District IV meeting. It was an unusual invocation and a warm meaningful one, and just recently it came into my hands. I am sure Mrs. Colopy will not mind

my using "her words" with which to close this column at the beginning of a New Year:

"Dear Lord, we are gathered here this afternoon with a spirit of friendliness, knowing that by sharing and working together, we are doing the will of God. Life as a doctor's wife can be compared to a football game—there are so many ups and downs!

"Help us to get a kick out of everyday living. . . .help us to tackle the problems that often seem so big. . . .don't let us get up-tight or thrown in this era of change and crisis.

"Please, dear God, guard and pad us with lots of patience and tolerance. Help us to carry our troubles with a smile. Signal us if we get out of bounds. We want to score well—with proper goals—so that we may enter, not sneak, into the clubhouse that you have prepared for tired doctors' wives. . . ."

---

## Northwestern Ohio Psychiatrists Elect Officers

The Northwestern Ohio Psychiatric Society recently elected officers for the 1972-1973 year. They are:

Ernest Raab, M.D., president; 2828 W. Central Avenue, Toledo 43606;

Robert E. Walden, M.D., Toledo, president-elect;

Roberto Pagarigan, M.D., secretary; 40 Clay St., Tiffin 44883;

Morris Weinblatt, M.D., Toledo, treasurer;

Nathan Kelb, M.D., Lima, delegate;

F. Breaux Martin, M.D., Toledo, alternate delegate.

The Society is a regional chapter of the Ohio Psychiatric Association and the American Psychiatric Association.

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The largest freshman class in the history of the Holzer Medical Center's School of Nursing entered the Gallipolis school this fall. One part-time and 45 full-time students bring the total enrollment of the school to 102.

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A program entitled "The Small Intestine and Colon," will constitute the third annual course in gastroenterology to be presented at the Ochsner Medical Center, February 1-3. For details, contact the Alton Ochsner Medical Foundation, 1514 Jefferson Highway, New Orleans, La. 70121.

## Cited for Meritorius Service



Dr. Drew L. Davies proudly displays A Certificate of Appreciation signed by President Richard M. Nixon, and the Meritorious Service Award of the U. S. Selective Service System, presented to him for his long and effective service as chairman of the Ohio Volunteer Medical Advisory Committee to the Selective Service System.

In cooperation with local volunteer advisory committees, the state committee makes recommendations to the Selective Service System regarding the availability of physicians, dentists, and allied specialists under the Military Selective Service Act.

Dr. Davies has a long and outstanding record in both professional and volunteer work. He is a veteran of both World Wars I and II and during the second war attained the rank of captain in the Navy Medical Corps. He is on the faculty of the Ohio State University College of Medicine, a specialist in the field of traumatic surgery. He has a long career in the safety service of the local Red Cross chapter and has served as director of safety services for the National American Red Cross. He has served many years as surgeon for the State Highway Patrol.

Other OSMA Committees on which he has served include the Committee on Emergency and Disaster Medical Care, the Committee on Traffic Safety, the Committee on Medical Care of Veterans, the Committee on Civil Defense, and the Joint Committee on School Bus Driver Examinations.

A Fellow of the American College of Surgeons, Dr. Davies is continuing his practice in Columbus.



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## AMA Clinical Convention Proves to Be One of Busiest

THE American Medical Association Clinical Convention held in Cincinnati, November 26-29, 1972 proved to be one of the busiest on record. The House of Delegates acted on 59 reports and 65 resolutions, the greatest total number of measures presented at a clinical meeting in several years.

The issue of Professional Standards Review Organizations was the No. 1 topic at the Convention. The House determined the AMA would provide a dominant role of leadership in the implementation of the PSRO program to assure the best interests of the public and the profession are preserved.

An AMA Advisory Committee on Professional Standards Review will be created by the Board of Trustees. It will include members of the Board and Council on Medical Service. In addition, the Board may invite other appropriate organizations to participate.

Among responsibilities of the Committee are these:

1. To provide input from the medical profession in the development of rules and regulations which will govern the PSRO program.

2. To assist state medical associations, or state medical associations in concert with county societies, in developing PSRO's and to recommend structures and operating mechanisms for such organizations.

3. To aid in defining appropriate geographic boundaries for PSRO's, especially where more than one state may be involved.

In addition to the eight areas of responsibility outlined in Report Z (including the above) floor amendments added several more which would have the Committee:

Develop and distribute information about PL 92-603 to constituent societies; monitor the effect of PSRO on medical care, and report to each future House session; and instruct the House and state societies on procedures to follow "whenever rules and regulations interpreting the law and published in the Federal Register seem to be contrary to the spirit of the law as written."

### School Definition Rejected

Overriding a reference committee recommendation for approval, the House of Delegates re-

ferred back to the Council on Medical Education a report on the functions and structure of a medical school for additional study and suggestions.

The document is intended to modernize an existing statement, last revised in 1957, and offers criteria by which medical schools are evaluated for purposes of accreditation. A similar position paper had been approved last month by the Association of American Medical Colleges at its annual meeting in Miami Beach.

The AMA report defined a medical school and described its mission, and discussed educational programs, administration and governance, faculties, students, finances, facilities, and accreditation.

Leading the successful fight to override the committee's recommendation was Frederick P. Ogood, M.D., Toledo, who contended there were "subtle implications" in the report, and suggested its referral to the CME.

Several other delegates agreed, expressing the desire for more time for study, while "failing to see the urgency" of taking immediate action.

The delegate vote for referral was overwhelming.

### Address of the President

Dr. Charles A. (Carl) Hoffman, AMA President, offered bold suggestions as to how some long-decried national health problems might be solved.

The major problems, he said, are protecting Americans from financial ruin due to catastrophic illness, and the maldistribution of physicians as it affects the inner city and rural areas.

Dr. Hoffman, in reporting on his recent European survey of health care systems, showed a film of his interviews in England, Sweden, West Germany and the Soviet Union.

"What impressed me most," he said, "was the fact that the health care problems of the United States also are to be found in these other nations—where economic, political and cultural differences are so different from our own."

The nations he visited also grapple with maldistribution, which limits access to medical care for some citizens.

"But we in the U.S. appear to be sadly deficient in insurance coverage for catastrophic illness," the AMA president said. "No one in this affluent nation should suffer financial deprivation

or bankruptcy because of serious illness or accident.”

The Huntington, W. Va., urologist said insurance company executives had told him there were “insoluble problems” involved in providing such coverage. “But I have a suggestion which may help solve one of those problems, that of abuse.

“I suggest that a number of conditions be specified as catastrophic—hemophilia, stroke, severe burns and severe injuries, for instance.”

Perhaps certain stipulations could be made to provide coverage for unforeseen or extremely unusual situations, he said, adding:

“A precedent has been established by HR 1, which recently became law and provides financial protection for those undergoing renal dialysis.

“I cannot believe that this proposal is not

workable.”

As for maldistribution of doctors, Dr. Hoffman offered what he called “perhaps a revolutionary suggestion” on how to get physicians into rural areas: A “strictly voluntary” program under which needy students could get a medical education with state or federal financing, by signing an unbreakable contract to practice in needy areas for three or four years. He would have no option to repay the loan in cash.

To control the program, medical societies and licensing boards could grant temporary licenses, allowing the physician to practice only in the designated community. After the period of service was completed, the physician would get complete licensure.

In regard to doctor shortages in the inner cities, Dr. Hoffman said, “It is possible that part

## All's Well That Ends in Roses



It all started at the AMA Clinical Convention of 1971 when the Michigan Delegation “did find cause to direct unsolicited and immature attention to a Big Ten athletic event contested in Ann Arbor.” At that time the Michigan Delegation presented to the Ohioans “a barbaric and medieval therapeutic item” directed toward the Buckeye head coach. With the worm turned in 1972, Dr. Richard L. Meiling, Ohio Delegation chairman, returned the “unused” item to Dr. Donald N. Sweeney, Jr., of the Michigan Delegation, and with it “the newest electronic computerized football learning device,” shown above.





It all ended in good humor and roses when Dr. Sweeney presented the above "maize and blue" bouquet to Dr. Meiling and the Ohio Delegation, a tribute to the Rose Bowl bound Buckeyes.

of the solution may lie in neighborhood health centers."

### Budget and Fiscal Restraint

A summary of the 1973 AMA budget drew congratulations from the reference committee which studied it. And budget-cutting action recently taken by the Board of Trustees was approved by the House.

"In considering the budget for 1973, the Board of Trustees made a determined effort to exercise fiscal restraint, and to allocate our financial resources according to priority needs," the Board said in Report A. The budget summary anticipates 1973 gross revenues of just over \$37 million and operating expenses of \$36,322,000, leaving a projected surplus of about \$800,000.

Fiscal restraint action taken by the Board included the termination of four councils and six committees. One resolution sought to rescind termination of the Council on Drugs, but the House instead adopted a substitute resolution. That mea-

sure says the Board shall continue to use "all appropriate AMA resources and methods indicated, to the point of establishing a committee, if necessary, to delineate clearly the independent AMA policy on drugs and drug therapy."

Another economy action was making specialty journals available on subscription only, starting January 9. *Prism*, the AMA's new socioeconomic publication, will be sent as a membership benefit, along with *JAMA*.

### Medical Care of the Poor

Since the House in 1971 urged creation of state and local medical society committees concerned with health care of the poor, 23 state and 29 local societies have set up such panels, and they are now developing programs to improve health care services. It was emphasized that local systems must be developed to meet local needs.

On related measures, the House urged organized medicine to continue to provide assistance and work to improve the quality of care in free



clinics, which are increasing in number around the nation. Currently, there are more than 200 of them in 30 states.

They provide a variety of services and, as the report approved by the House points out, for those people who might not otherwise receive **any** health care, they are filling a real need.

The House also approved a statement on the concept of health outreach, whereby lay workers serve to bridge the cultural gap between patients, professional staff and the community, and assist in effective delivery of health care. Among several sound reasons for using such workers, the report says, is that they free doctors and other health professionals to better utilize their time and thus extend the scope of their services.

### Blood Banks

The House adopted a report which deals with new federal regulations in regard to collection and distribution of blood. Among the recommendations to be given to a federal panel on blood banking are:

That operating standards of the American Association of Blood Banks and the American Red Cross be recognized and accepted; that physicians be represented on any national panel set up to advise on procurement or use of blood, and that programs to increase voluntary blood donation be encouraged.

### Young Physicians

The Council on Long Range Planning and Development will now be expanded to include one Intern and Resident member of the AMA as a full voting Council member.

Proposals to appoint an intern or resident to the Councils on Medical Education and Medical Service were deferred for further study.

For the first time in the history of the AMA, a medical student took his seat in the House of Delegates. In another action, the House set annual dues for student AMA members at \$15.

### IRS Ruling

The House was informed that an Internal Revenue Service ruling—which barred physicians from withdrawing voluntary contributions to their Keogh Law plan prior to disability or age 59½—will be revised to permit withdrawal of such contributions made to a qualified plan prior to March 6, 1972.

### Medicare Changes Urged

Revised Medicare regulations providing for a one-year statute of limitations and right of appeal in cases in which intermediaries can challenge

the medical necessity for hospitalization have been advocated by the AMA.

A resolution dealing with retrospective denials of Medicare hospitalization also called for an “unchallengeable” seven-day grace period—a proposal which was referred to the Board of Trustees for a report next June.

These actions were among many the House took on Medicare-related items. In others, Medicare and Medicaid-related items, delegates:

- Turned down a strongly-worded resolution calling for Congressional study of Medicare mismanagement.

- Referred to the Board for a report next June a resolution asking revision of the “more than allowable charge” phrase in the Medicare Explanation of Benefits form.

- Reaffirmed a previous AMA position that regulations authorizing Medicare carriers to disclose names of physicians accused of furnishing services to beneficiaries in excess of their medical needs be amended to require prior review by medical society committee.

- Filed a report of the Council on Medical Service citing the council’s attempts to persuade the Bureau of Health Insurance to send duplicate statements to physicians when Medicare payments are made directly to patients.

- Referred to the Council on Medical Service a resolution directing the AMA to work for clarification of rules governing physician visits to nursing home patients under Medicare and other federally-sponsored or supported medical payment programs.

### Revised Medigap Bill to Be Introduced

Reintroduction of a revised version of AMA’s Medigap health insurance plan in the 93rd Congress was approved by the House of Delegates after the Board reported Medigap will continue to emphasize “the principles that medicine believes should be included in any national health insurance proposal.”

Foremost among these is preservation of the physician-patient relationship. Delegates stressed that “the best interests of patients cannot be served under conditions destructive to the mutual trust and responsibility essential to the physician-patient relationship.”

In reaffirming its support for a pluralistic health care system, delegates opposed the concept of health maintenance organizations-contract practice as the “exclusive or major means” of providing health care delivery.

In updating Medigap, the Board noted, advice was sought from all specialty and state medical societies, and from the National Medical Association. In addition, AMA will consult with

the American Dental Association about the possible inclusion of dental benefits, and with the National Association of Retail Druggists and the Pharmaceutical Manufacturers Association about possible drug benefits.

Other legislative matters drawing considerable attention from delegates were certificate of need legislation and methadone maintenance.

In refusing to urge a moratorium on further certificate of need legislation, the House called for continued study of the issue by the Council on Medical Service, and directed the council to develop guidelines for such legislation. The House noted that the development of such guidelines did not imply AMA approval.

Several physicians had expressed concern about the impact of certificate of need programs, particularly in "identifying hospitals as public utilities subject to franchising control by the government." Others, however, reported such laws are working well in their states and have the support of the state medical society.

Delegates called on state medical societies to take the lead in establishing methadone maintenance programs in hospitals. Such action anticipates government rules—expected by the end of the year—regulating methadone maintenance programs and probably restricting physician prescribing of the drug.

Delegates were concerned that such rules might permit physicians inadequately trained in the use of the drug to provide incomplete services for patients using the drug as treatment for heroin addiction.

In related action, delegates:

- Urged federal legislation to provide benefits for chronically ill and disabled patients.
- Called for further study of a proposal that a security bond be required to eliminate "nuisance" malpractice suits.
- Opposed the "Current Medical Care Survey" being conducted by the federal Bureau of the Census, because of "deficiencies in the methodology."
- Postponed temporarily consideration of supporting the establishment of a national tumor registry.
- Urged the Model Cities Program—at all levels—to seek advice from practicing physicians in planning health programs, and requested that such physician involvement at the local level be a requirement for federal approval of local programs.

### Public Health Concerns

Public health concerns—such as sickle cell disease, smallpox immunization and gonorrhea control—received considerable attention from the House. The sickle cell and smallpox issues, in particular, created considerable debate.

A resolution on sickle cell disease was approved calling on the AMA to continue to encourage research and educational efforts dealing with the sickle cell problem and encourage state, county, and local health departments to disseminate information in all schools with susceptible populations.

In an extremely close vote, the delegates approved a resolution encouraging "modern biological virologists to seek new methods of immunization against smallpox producing less reaction and greater length of immunization," and urging that "physicians, while observing contraindications, have the option of immunizing patients against smallpox, whether or not immunization is required by the U.S. Public Health Service or other countries."

The "alarming increase" in the incidence of venereal disease, particularly gonorrhea, resulted in approval of a resolution which:

- Urged the AMA to support public education, effective and adequate case-finding, prompt reporting, and research to develop vaccines.
- Urged physicians to take all appropriate measures to reverse the rise in venereal disease.
- Urged medical societies to support increased appropriations for VD research.
- Urged medical societies to support legislation permitting physicians to legally treat minors with venereal disease without parental consent.

In another public health measure, the delegates endorsed fluoridation of public water supplies as an "effective method of reducing dental caries."

### Aetna Actions to Be Studied

The AMA Council on Medical Service has been instructed to collect information from physicians and their medical societies concerning claims processing and reimbursement procedures employed by Aetna Life and Casualty Co.

Delegates considered a report outlining a number of actions which Aetna officials say they have taken in an effort to modify or eliminate practices which had been criticized by organized medicine. Those practices, however, remain essentially unchanged in some areas of the country, according to testimony offered during the Convention.

Accordingly, delegates declined to file the Council on Medical Service's Aetna report, but instead referred it back to the council with instructions to submit another report next June.

Council members accepted the charge, but indicated their job will be difficult unless physicians and medical societies come forward with information on Aetna's claims procedures.

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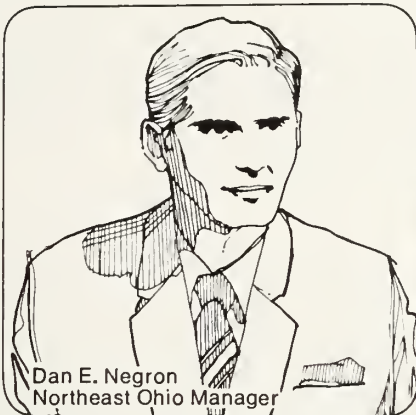
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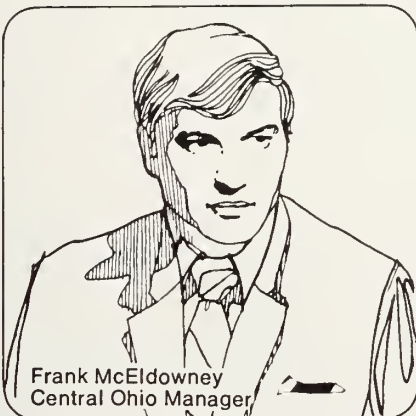
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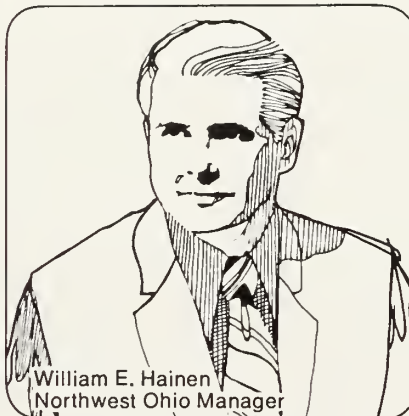
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tated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or over-sedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the

elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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FEBRUARY • 1973  
VOL. 69 NO. 2

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26 FEB 1973

# *The Ohio State* MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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EXCHANGE OFFICE  
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**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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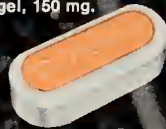
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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during December. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA  
F. George Estafanous  
Cleveland

Charles D. Kenyon  
Paul V. Kollman  
Arthur Sia Pua

HAMILTON (Cincinnati) MONTGOMERY (Dayton)  
Alastair M. Connell  
Richard Dorsey  
James D. Faulkner

Giselle T. Bretz  
Martin L. Norton

## Construction Starts on Toledo Medical Library

The Medical College of Ohio at Toledo recently conducted ground-breaking ceremonies for the \$7 million medical library, the second building started on the college's growing west campus on Arlington Avenue, between Detroit Avenue and Byrne Road in Toledo.

Dr. Marion C. Anderson, college president, said that the future building will serve as the focal center for the college's new campus. In addition to the library, the structure will house a variety of student services, a dining area and academic administration offices. Completion is expected by the fall of 1974.

The first building on the west campus, the Basic Sciences Building, was started in September 1970. The estimated cost was announced as \$12 million.

The Medical College of Ohio at Toledo was established in 1964 by action of the Ohio General Assembly. Its first class of 32 students entered in September 1969, with 28 of the class graduating in June 1972. The third and fourth classes started

with 48 each. As facilities increase, admissions target is between 150 and 200 medical students.

The college is presently based on the grounds of the former Lucas County Hospitals, an area east of Detroit Avenue called the "east campus."

## More Women Are Driving and More Involved in Accidents

Ohio's traffic death toll for the first ten months of 1972 exceeded by 56 the number of deaths recorded for the same period in 1971 according to traffic accident summaries received by Ohio Department of Highway Safety.

The report shows a total ten-month traffic death toll of 2009 persons compared to 1953 deaths in 1971 for the same period.

It was pointed out that the entire increase of 56 deaths is reflected in the increased number of female passengers, drivers and pedestrians killed in traffic this year. This trend to higher female traffic fatalities—started in June, with significant increases through the months of July and August—exceeded last year's count by 63 in August before dropping back to the present 56 differential. The total number of female traffic victims thus far in 1972 is 598 compared to 542 in 1971.

The rapidly increasing number of driver licenses issued to female drivers during the past decade is now being reflected in traffic crash statistics. The percentage of driver licenses issued to female drivers has risen from 28 percent in 1952 to 43 percent of the total drivers licensed in 1971. Also, females are driving 48 percent of the total vehicular miles driven by males resulting in a higher traffic crash exposure rate, the report stated.

## Laser Safety Lacking in Many Schools

A joint State-Federal survey has found serious shortcomings in safety practices in the use of potentially dangerous lasers in high school and college science classes.

Preliminary survey results have been sent to radiation control agencies in all States, the District of Columbia, Puerto Rico and the Virgin Islands. FDA has also provided these agencies with recommendations to improve safety in operating the light intensifying devices and requested that the recommendations be provided to all school authorities.

FDA's Bureau of Radiological Health jointly surveyed 288 lasers with state health agencies in seven states.

## MDs in the News

Dr. Charles E. Billings, assistant professor of medicine, Ohio State University, was named vice-president (aerospace medicine), at the recent 19th annual meeting of the American College of Preventive Medicine in Atlantic City. He was one of four vice-presidents named, one for each of the preventive medicine subspecialties.

Dr. Richard L. Wenzel, health commissioner of Toledo, was reelected Regent at the recent 19th annual meeting of the American College of Preventive Medicine in Atlantic City. His Region includes Ohio, Indiana, Illinois, Missouri, Iowa, Minnesota, Wisconsin, and Michigan.

Dr. Byron E. Neiswander who recently announced his retirement after some 38 years of practice in Doylestown, was commended by Governor John J. Gilligan and presented the "Governor's Award for Community Action."

Dr. Alastair M. Connell, director of the Division of Digestive Diseases, University of Cincinnati Medical Center, has been honored with a Fellowship in the Royal College of Physicians in Edinburgh, Scotland. He has been a member of the organization since 1964.

Dr. Donald M. Glover, Cleveland, was cited by Governor Gilligan for his many years of devoted care and treatment of handicapped children under the Bureau of Crippled Children Services. He has been working with the bureau since 1935, as a member of the Medical Advisory Board since 1946, and as the board's chairman since 1970.

Dr. Oscar D. Ratnoff, professor of medicine at Case Western Reserve, and director of hematology in the Department of Medicine at University Hospitals, Cleveland, was awarded the annual William Dameshek Medical at the recent meeting of the American Society of Hematology in Hollywood, Fla. Dr. Ratnoff also was elected vice-president of the Society.

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# New Book Emphasizes Programs and Issues in Health Care

Just off the press is a book entitled *Topics: Information on Significant Programs and Issues in Health Care*.

Published by the American Medical Association, it is a compendium of articles on 156 subjects ranging from abortion to zoonoses. Included are some of the most important issues in health care today—national health insurance, indigent care, drug dependence, population growth, air and water pollution, health maintenance organizations (contract practice), and many others.

Activities in health planning, health education, nutrition, environmental health, health manpower, medical education, peer review, health care organization and delivery, mental health, and

other fields of both public and professional interest are discussed. Descriptions of major governmental health care programs, such as Medicare and Medicaid, are provided, as are statistical data and information about pertinent legislation.

Available in one book, for the first time, is a collection of information highlighting a wide range of the AMA's current interests, activities, policies, programs, and publications. Also listed are AMA departments that may be contacted for additional information on any of the subjects.

Copies of *Topics* are available from the Order Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. Payment should accompany orders. The price is \$1.00 for orders from the United States, U.S. Possessions, Canada, and Mexico; \$1.50 for orders from other countries. For U.S. medical students and hospital interns and residents, the price is \$.50.

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## Regional Medical Program Coordinator Takes Office

Wallace B. Dorain, M.D., is the new coordinator of the Ohio Regional Medical Program, a combined unit comprised of the two programs formerly known as the Ohio State Regional Medical Program and the Northwestern Ohio Regional Medical Program.

William G. Pace III, M.D., assistant dean at Ohio State University College of Medicine, who served as coordinator of the Columbus based program, and C. Robert Tittle, M.D., clinical professor of medicine at the Medical College of Ohio at Toledo, who served as coordinator of the Toledo based unit, are continuing to serve the program as medical representatives.

Dr. Dorain, before accepting the new post, was vice-chief of surgery at Blodgett Memorial Hospital in Grand Rapids, Mich. Now certified by the American Board of Surgery and a Fellow of the American College of Surgeons, he was a general practitioner prior to entering the field of surgery in 1954.

The Ohio Regional Medical Program comprises some 73 counties in Ohio. Two other programs operate in the State, the Northeast Ohio RMP, with headquarters in Cleveland, and the Ohio Valley RMP, based at Lexington, Ky., and serving four counties in Southeastern Ohio.

Regional Medical Programs were created through Public Law 89-239, passed by Congress in 1965 to assist the nation's health resources in making available patient care for heart, cancer, stroke and related diseases. Kidney disease was added in 1970.

## Family Practice Board Examinations Announced

The American Board of Family Practice announces that it will give its next two-day written certification examination on October 20-21, 1973. It will be held in various centers geographically distributed throughout the United States. Information regarding the examination can be obtained by writing:

Nicholas J. Pisacano, M.D., Secretary,  
American Board of Family Practice, Inc.,  
University of Kentucky Medical Center,  
Annex #2, Room 229,  
Lexington, Kentucky 40506.

It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications is August 1, 1973.

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## Continuing Education Opportunities for Physicians in Ohio

**Surgical Seminars** — Medical College of Ohio at Toledo and Northwestern Ohio Institute for Continuing Medical Education; one hour a day, one day a week, for 88 weeks; dates on request.

**Clinical Days on Emergency Care** — 80 hours of instruction on 20 separate days, September to June; Medical College of Ohio at Toledo, 945 S. Detroit Ave., Toledo 43614.

**Introductory Course in Nuclear Medicine for Physicians** — Nuclear Medicine Institute, 6760 Mayfield Rd., Cleveland 44124; five-day courses; dates upon request.

### February

**Ohio State University College of Medicine, Continuing Medical Education Conferences;** for details contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210:

**ENT Conference** — February 15, Stouffer's University Inn

**Group Psychotherapy** — Fridays, February 16 through May 4, Center for Tomorrow

**Electromyography XII** — February 19-22, Dodd Hall and Stouffer's Inn

**Orthopaedic Problems** — February 21, Center for Tomorrow

**Cleveland Clinic Educational Foundation:**

**Drugs and Treatment Techniques in Angiograph,** February 7-8

**Pharmacology and Clinical Effectiveness of Anti-inflammatory Drugs,** February 21-22

**Sports Medicine,** February 28-March 1

**Fifth Annual Infectious Disease Conference** — Office of Continuing Education (CONMED) of the University of Cincinnati, at the center, February 23.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

**Arrhythmias**—Youngstown Hospital Association, South Unit, February 26, 4:00 p.m.; Drs. A. V. Whittaker and C. G. Battistelli.

**Sixth Ohio Intercontinental Conference on Diagnostic Medicine** — Ohio Academy of Family Physicians; 24 hours of instruction, February 26 through March 11.

### March


**Studies on the Regulation of Sodium Balance** — Veterans Administration Center, 4100 W. Third Street, Dayton 45428, March 2, 2:30 to 4:30 p.m.; lecturer, Jay H. Stein, M.D., Gustav Hirsch Professor of Medicine, at Ohio State; contact, Hassan Mehbod, M.D., at the center.

**Fourth Biannual Short Course on Laser Safety** — Sponsored by the Medical Laser Laboratory and the Office of Continuing Medical Education (CONMED) of the University of Cincinnati, March 5-9, at the University; contact Laser Safety Course, CONMED, 114 Medical College, Cincinnati 45219; tuition, \$325.

**Eighth Annual Cancer Symposium** — Akron City Hospital, 525 E. Market Street, Akron 44309; March 14-15.

(Continued on Page 90)





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the compatible vasodilator

- no reported increase of intraocular pressure
- conflicts have not been reported with miotics, corticosteroids, antihypertensives, hypoglycemics or diuretics

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**INDICATIONS:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**COMPOSITION:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**DOSAGE AND ADMINISTRATION:** 10 to 20 mg. three or four times daily.

**CONTRAINDICATIONS AND CAUTIONS:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**ADVERSE REACTIONS:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**SUPPLIED:**

Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose  
20 mg.—bottles of 100, 500 and Unit Dose

**Mead Johnson**  
LABORATORIES



## Educational Opportunities in Ohio — *Continued*

**Ohio State University College of Medicine, Continuing Medical Education Conferences;** for details contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210:

**Ophthalmology Conference** — March 5-6, Center for Tomorrow

**Neurochemistry** — March 12-15, Center for Tomorrow

**Neurology Conference** — March 18, Center for Tomorrow

**Pediatrics Clinic Day**, March 21, at Children's Hospital, Columbus

**Dermatology and Allergy** — March 28, Center for Tomorrow

**General Practice Seminar** — March 31-April 1, Center for Tomorrow

### **Cleveland Clinic Educational Foundation:**

**Medical Progress and Its Relationship to Dentistry**, March 7-8

**Advances in Urology**, March 14-15

**Hodgkins Disease, Leukemia and Lymphoma**, March 21-22

**Treatment of Neurological Diseases**, March 28-29

**Cincinnati VA Hospital Annual Seminar** — March 15, at the hospital, 3200 Vine Street, Cincinnati 45220.

**Low Renin Hypertension**—Youngstown Hospital Association, South Unit, March 15, 8:00 a.m.; Dr. Randall H. Travis, assistant clinical professor of medicine, Case Western Reserve University.

**Upper Respiratory Infections and Related Diseases**—Youngstown Hospital Association, South Unit, March 26, 4:00 p.m.; Medical Seminar; Drs. R. J. Smith and R. Hoffler.

**Treatment in Psychiatry—Theory and Practice** — at the VA Hospital, 1000 Brecksville Rd., Cleveland 44141; cosponsored by the Northwestern Ohio Institute for Continuing Medical Education and the Medical College of Ohio at Toledo; 49 hours, March 26-30.

### **April**

**Association of Physicians of the State of Ohio**—Quarterly meeting, Cleveland Psychiatric Institute, April 6; contact Virginia S. Edwards, M.D., Secretary, 347 Lexington Ave., Mansfield 44907.

**Ohio State University College of Medicine, Continuing Medical Education Conferences;** for details, contact OSU Center for Continuing Medical Education, 410 W. 10th Ave., Columbus 43210:

**Cancer Symposium**, April 4

**Lederle Conference**, April 8

**Sex and Spinal Cord Injuries**, April 12-13

**Plastic Surgery in General Practice**, April 25

**Anesthesia**, April 27

**Myelomeningocele Conference**, April 28-29

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106;

**Current Topics in Clinical Microbiology**, April 4-5

**Peripheral Vascular Disease**, April 25-26

**Orthopaedic Surgery**, April 11-12

**The Ladies You Know**—Sheraton-Columbus Motor Hotel, April 8; jointly sponsored by Lederle Laboratories and Ohio Academy of Family Physicians and Ohio State University.

**To Bypass or Not to Bypass**—Youngstown Hospital Association, South Unit, April 9, 4:00 p.m.; Medical Seminar; Drs. J. L. Calvin and R. A. Weiss.

**Chronic Glomerular Disease: Clinical Pathological Correlations and Indications for Treatment**—Youngstown Hospital Association, South Unit, April 19; 8:00 a.m.; Dr. Robert S. Post, associate professor of medicine, Case Western Reserve University.

**Clinical and Laboratory Estimation of Renal Function**—Youngstown Hospital Association, South Unit, April 23, 4:00 p.m.; Medical Seminar; Drs. R. A. Bacani and Y. O. Sheth.

**Family Relations Workshop**—April 27-29 at Salt Fork Lodge, Cambridge; sponsored by Ohio Academy of Family Physicians.

**University of Cincinnati College of Medicine (CONMED)**—Eden and Bethesda Avenues, Cincinnati 45219:

**Velo-Pharyngeal Insufficiency**, May 3

**General Surgery**, May 16-17

**Internal Medicine — Current Concepts of Clinical Problems**—Cosponsored by the American College of Physicians, May 21-25

## Educational Opportunities in Ohio — *Continued*

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106:

**Organization and Administration in Anesthesiology**, May 5-6

**Advances in Dermatology**, May 9-10

**Newborn Conference**—Ohio State University College of Medicine, May 2-3, at the Center for Tomorrow; contact OSU Center for Continuing Medical Education, 410 W. Tenth Ave., Columbus 43210.

**Endoscopy and Gastrointestinal Bleeding**—Youngstown Hospital Association, South Unit, May 17, 8:00 a.m.; Dr. Reed T. Keller, of Case Western Reserve University, guest lecturer.

**Cleveland Society of Obstetricians and Gynecologists**—Educational forum at the Cleveland Clinic; March 14, 3:00-6:00 p.m.; topics, Stress Incontinence, Ultrasonic Diagnosis, Placental Morphology, Cytohormonal Analysis; speakers, Dr. Peter Beck, University of Alberta; Dr. H. I.

Perlmutter (Ph.D.), Dr. S. Aladjem, Dr. A. H. Ansari, and Dr. C. R. Cowdrey; 6:30 dinner meeting at the University Club, with Dr. Beck speaking on "Surgical Anatomy of Stress Incontinence and Pelvic Malignancy." Contact Kathryn Hoffman, M.D., 806 Rose Bldg., Cleveland 44115.

**Research in Esophageal Repair**—Veterans Administration Center, 4100 W. Third Street, Dayton 45428; May 18; 2:30 p.m.; Dr. Charles L. Cogbill; **A New Approach in the Treatment of Esophageal Perforation**, Dr. Krishna V. S. Rao; **A New Treatment for Esophageal Stricture**, Dr. Mahood Mir.

**Internal Medicine, Current Concepts of Clinical Problems**—Sponsored by the American College of Physicians and the University of Cincinnati College of Medicine; May 21-25 at the Medical Center, Cincinnati.

**Digitalis and Injured Heart**—Youngstown Hospital Association, South Unit, May 28, 4:00 p.m.; Drs. W. H. Bunn, Jr., and R. D. Arnott.

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# The When and Where of Continuing Medical Education in Ohio

**R**ECENTLY the Center for Continuing Medical Education, The Ohio State University completed a study of educational needs of Ohio physicians in selected clinical conditions and preferred educational methods and techniques. Conferences and seminars and Ohio Medical Education Network broadcasts offered by the Center during 1971-1972 have been designed in light of the data from this study. Results of this study were published in the October, 1972 issue of the OSMA Journal, pages 924-927.

Even though the topics and methods of the continuing medical education programs are now more appropriate, the timing of the conferences, seminars, and workshops is not always compatible with the physicians schedule. This report describes the results of an additional study completed by the Center for Continuing Medical Education during January-February, 1972, dealing with timing and location of continuing medical education conferences and seminars.

## Purpose of Study

The purpose of this study was to determine, through a questionnaire, preferences for timing and location of continuing medical education conferences and seminars by selected Ohio physicians.

Data were gathered in two basic areas:

1. The professional characteristics of the physicians.
2. The physicians' preferences as to the timing and location of conferences and seminars.

---

## The Authors:

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## Sources and Treatment of Data

A questionnaire inquiry method was used in gathering data for this study. The physicians were asked to give information as to their practice situation in terms of type of practice and organization of practice. The physicians were also requested to indicate their specialty from a list of 36 specialties.

In addition the physicians were asked to give their preferences as to location, length, and preferred day or days of the week for the continuing medical education conferences and seminars.

Finally, the physicians were asked to identify how they heard about the conferences and seminars.

## Distribution of Questionnaire and Response

On January 31, 1972, the questionnaire was sent to 300 Ohio physicians. The 300 physicians represented a 2½ percent stratified (by medical specialty) random sample of the M.D. physician population in Ohio.

By March 1, 1972, over 100 questionnaires had been returned. The questionnaires were coded so as to identify the nonresponders in the event follow-up activity was deemed necessary. Since an initial response of over 30 percent was obtained no follow-up effort was planned.

## Treatment of Data


The object of the treatment of data is to identify when and where the responding physicians want their continuing medical education conferences and seminars and how they learn that the programs will be conducted.

## Presentation of Data

Ninety percent of the responding physicians are in private practice. Fifty-two percent indicated they are in solo practice, 19 percent are in two-man partnerships while the remainder were equally divided between group practice and institutional affiliation.

The responses received represent nearly 70 percent of the specialties surveyed. In 23 of the 36 specialties included there was a response of at least 30 percent. For example there were 64 family





Colic? Diarrhea? Eczema? Asthma?  
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physicians surveyed with 32 responding, 28 general surgeons with 13 responding, 13 psychiatrists with 5 responding, etc.

It should be kept in mind that the data may reflect GP preferences to a greater extent than other medical specialties.

Location of Continuing Medical Education Conferences and Seminars

The majority of the responding physicians indicated that they prefer their programs be conducted at University Medical Centers (42 percent) or community hospitals in their area (41 percent). Very few physicians indicated a preference for large distant cities or remote lodges and retreats.

TABLE 1. Location of Continuing Medical Education Conferences and Seminars

| Site                           | Number of Responses | Percentage |
|--------------------------------|---------------------|------------|
| University Medical Centers     | 42                  | 42         |
| Community Hospitals in My Area | 41                  | 41         |
| Large Distant Cities           | 8                   | 8          |
| Remote Lodges and Retreats     | 9                   | 9          |

Length of Continuing Medical Education Conferences and Seminars

Nearly 40 percent of the responding physicians (38 percent) prefer one-day programs while 20 percent prefer two-day programs. An additional 20 percent prefer three-day programs. Programs lasting longer than three days are not as popular.

TABLE 2. Length of Continuing Medical Education Conferences and Seminars

| Day            | Number of Responses | Percentage |
|----------------|---------------------|------------|
| 1 day or less  | 38                  | 43         |
| 2 days         | 20                  | 22         |
| 3 days         | 20                  | 22         |
| 4 days         | 4                   | 5          |
| 5 days         | 5                   | 6          |
| 6 days or more | 2                   | 2          |

Day of Week for One-Day Continuing Medical Education Conferences and Seminars

Table 3 indicates that Sunday is the most popular day for a one-day continuing medical education program, followed by Wednesday, Saturday, and Thursday in that order. Tuesday is the least popular day.

TABLE 3. Day of Week for One-Day Continuing Medical Education Conferences and Seminars

| Day       | Number of Responses | Percentage |
|-----------|---------------------|------------|
| Sunday    | 32                  | 35         |
| Monday    | 5                   | 6          |
| Tuesday   | 0                   | 0          |
| Wednesday | 22                  | 25         |
| Thursday  | 11                  | 13         |
| Friday    | 6                   | 7          |
| Saturday  | 12                  | 14         |

Days of the Week for Two-Day Continuing Medical Education Conferences and Seminars

Saturday-Sunday is the most popular time for two-day programs as reported by responding physicians. Wednesday-Thursday is next in popularity followed by Thursday-Friday.

TABLE 4. Days of the Week for Two-day Continuing Medical Education Conferences and Seminars

| Days               | Number of Responses | Percentage |
|--------------------|---------------------|------------|
| Sunday-Monday      | 6                   | 8          |
| Monday-Tuesday     | 4                   | 5          |
| Tuesday-Wednesday  | 4                   | 5          |
| Wednesday-Thursday | 12                  | 15         |
| Thursday-Friday    | 11                  | 14         |
| Friday-Saturday    | 7                   | 9          |
| Saturday-Sunday    | 37                  | 44         |

Days of Week for Three-Day Continuing Medical Education Conferences and Seminars

As shown in Table 5, weekends remain a preferred time. Friday through Sunday is the most popular time for a three-day program followed by Monday through Wednesday and Thursday through Saturday in that order. The least popular time is Tuesday through Thursday.

TABLE 5. Days of Week for Three-Day Continuing Medical Education Conferences and Seminars

| Days                      | Number of Responses | Percentage |
|---------------------------|---------------------|------------|
| Monday through Wednesday  | 17                  | 23         |
| Tuesday through Thursday  | 0                   | 0          |
| Wednesday through Friday  | 10                  | 14         |
| Thursday through Saturday | 11                  | 15         |
| Friday through Sunday     | 25                  | 35         |
| Saturday through Monday   | 5                   | 7          |
| Sunday through Tuesday    | 4                   | 6          |

Ways of Learning About Continuing Medical Education Conferences and Seminars

By far the greatest majority of responding physicians learn of continuing medical education programs by announcements sent to their office or home. No distinction or preference between office or home was measured here.

TABLE 6. Ways of Learning About Continuing Medical Education Conferences and Seminars

| Media  | Number of Responses | Percentage |
|--|---------------------|------------|
| Word of Mouth from Colleagues                        | 3                   | 3          |
| Announcements Mailed to Home/Office                  | 86                  | 86         |
| Notices in Journals                                  | 10                  | 10         |
| Notices Newspapers or Spot Announcements on Radio/TV | 0                   | 0          |
| Other (Hospital Bulletin Boards)                     | 1                   | 1          |

Summary

The responding physicians prefer that their continuing medical education conferences and seminars be conducted either at University Medi-



we can provide  
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health insurance  
to . . .

# 99%

## of OSMA members—regardless of health history

Complete protection is available for you and your family with the OSMA sponsored Extra Cash Hospital Plan and comprehensive Major Medical Insurance. Also available to Ohio physicians are Disability Income Protection, Practice Overhead Expense Protection and Accidental Death, Dismemberment and Disability Insurance. Choose the plans that fill your insurance needs and send the coupon today for complete details. Or better yet, for immediate information, call us collect!

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TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

## APATHY • IRRITABILITY FORGETFULNESS • CONFUSION



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## A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

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shows how some senile symptoms can be treated.  
Four times as many aging patients showed  
striking improvement.

Each CEREBRO-NICIN capsule contains:  
Pentylentetrazole .....100 mg. • Nicotinic Acid ....100 mg.  
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L-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.  
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.

AVAILABLE: Bottles 100, 500, 1000

**SIDE EFFECTS:** Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

**INDICATIONS:** As a cerebral stimulant and vasodilator.  
**RECOMMENDED GERIATRIC DOSAGE:** One capsule three times daily adjusted to the individual patient.

**WARNING:** Overdosage may cause muscle tremor and convulsions.

**CONTRAINDICATIONS:** Epilepsy or low convulsive threshold.  
**CAUTION:** Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .

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\*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D.  
Double-blind study on the treatment of mentally confused patients. Reprinted  
from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964



cal Centers or at Community Hospitals in their area.

One-day programs conducted on Sunday are the most preferred programs according to responding physicians. Two-day programs conducted on Saturday and Sunday or three-day programs conducted on Friday, Saturday, Sunday are the next popular lengths and times for programs.

Physicians who attend The Center for Continuing Medical Education programs learn about them primarily via announcements mailed to their homes or offices.

#### Conclusions

More discriminating research needs to be done to isolate more specifically the timing and

location preferences for continuing medical education programs by specialty and subspecialty groups as against those of the family physician and those specialists with interest in general medicine.

It appears that institutions, societies and organizations conducting continuing medical education programs should give serious consideration to expanding their offering to include week-end programming. Like wise, consideration should be given to offering more programs at community hospitals.

Those involved in continuing medical education should be in constant communication with physicians and other health professionals to insure that their educational offerings include the correct topics at the right time and place.

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# impotence

due to androgenic deficiency in the American male.

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MUQUETS  
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Methyltestosterone N.F. - 5 mg.

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Methyltestosterone N.F. - 10 mg.

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Methyltestosterone N.F. - 25 mg.

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4-en-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

| INDICATION   | Average Daily Dosage Tablets |
|--|------------------------------|
| In the male:   |                              |
| Eunuchoidism and eunuchism   | 10 to 40 mg.                 |
| Male climacteric symptoms and impotence due to androgen deficiency | 10 to 40 mg.                 |
| Postpuberal cryptorchidism   | 30 mg.                       |

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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# MOVE-OUT STICKY MUCUS...



## In asthma, bronchitis...

"Many physicians use iodides intravenously when they suspect that the main reason for airway obstruction is sticky mucus but oral iodides are more likely to exert an expectorant action."<sup>1</sup>

"For the viscid sputum, potassium iodide (... preferable as enteric coated tablets) may be best."<sup>2</sup>

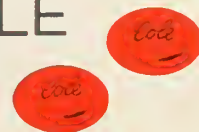
Provide tastefree, well-tolerated KI in convenient SLOSOL coated tablets—

# iodo-NIACIN<sup>®</sup>

Each SLOSOL coated tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg.

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# Promote Productive Cough-



"The productive cough serves the necessary purpose of removing excess mucus from the bronchial tree."<sup>3</sup>

"... there is clear evidence that the loosening of the bronchial mucus blanket must begin from within the underlying mucus glands where it is anchored and not from the surface. Complications of iodides are too occasional to avoid the use of this valuable medication."<sup>3</sup>

## Rx Information:

**INDICATIONS:** The primary indication for Iodo-Niacin is in any clinical condition where iodide therapy is desired. All of the usual indications for the iodides apply to Iodo-Niacin and include:

**RESPIRATORY DISEASE:** The use of Iodo-Niacin is indicated whenever an expectorant action is desired to increase the flow of bronchial secretion and thin out tenacious mucus as seen in bronchial asthma, and other chronic pulmonary disease. Iodo-Niacin has also proven of value in sinusitis, bronchitis, bronchiectasis, and other chronic and acute respiratory diseases where the expectorant action of iodide is desired.

**THYROID DISEASE:** Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy.

**ARTERIOSCLEROSIS:** Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

**OPHTHALMOLOGY:** Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption

of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

**SIDE EFFECTS:** Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous membrane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

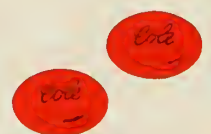
**DOSAGE:** The oral dose for adults is two tablets after meals taken with a glass of water. For children over eight years, one tablet after meals with water. The dosage should be individualized according to the needs of the patient on long-term therapy.

**HOW SUPPLIED:** Cole's Iodo-Niacin tablets are available in bottles of 100, 500 and 1,000. Slosol coated pink. NDC 55-6458.

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Each SLOSOL tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg. **Sig. *ij* tabs. t.i.d. p.c.**

**References:** 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allergy. 29:367, 1971.



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*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

**Are combination drug  
products useful in treatment  
involving concomitant use  
of two or more drugs?**

**Opinion**

**Results of a questionnaire to  
7,000 physicians:**

**62.9%**

**Believe combination drug  
products are useful.**

**13.8%**

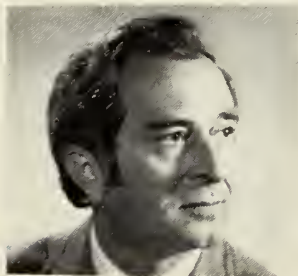
**Do not believe combination drug  
products are useful.**

# Are combination drug products useful in treatment involving concomitant use of two or more drugs?

## Opinion & Dialogue

### Doctor of Medicine

Louis Lasagna, M.D.  
Professor and Chairman  
Department of  
Pharmacology & Toxicology  
University of Rochester  
School of Medicine  
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility — and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription—which is more than can usually be said for

the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good ex-

ample of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investiga-

tors and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in use for a number of years and that have an apparently satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I am thinking particularly of penicillin-streptomycin combinations that patients—especially surgical patients—were given in injection. This made less discomfort for the patient, less demand on nurses' time, and few opportunities for dosage errors. To take such preparation off the market doesn't seem to be good medicine, unless actual usage showed a great deal of harm from the injection (rather than the preparation) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine which is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it can avoid taking the ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence in making the ultimate decision.



# Maker of Medicine

W. Clarke Wescoe, M.D.  
President  
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of pedantry, the "expert" denies the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he implies a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the rarest of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the usual dose being 650 mg. The other semantic ploy often called into play is to describe a combination product as rational or irrational.

Take antibiotic mixtures, the source of much of the criticism generated against

combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by \$443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irre-

futable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while

the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

## Opinion & Dialogue

What is your opinion, doctor?

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in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

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**Adverse Reaction:** GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. **Skin:** maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). **Renal toxicity:** rise in BUN, dose-related (see "Warnings"). **Hypersensitivity reactions:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. **Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. **CNS:** (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**NOTE: Concomitant therapy:** Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

\*Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection.  
†Case Report, Clinical Investigation Department, Lederle Laboratories.



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VER: CUM. INDEX MED. JAN-DEC, 1973, P4333.  
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# Early Services Available for Blind Children

For the information of physicians who may wish to contact one of the several branches of this service in Ohio, the following article has been prepared for *The Journal* by Richard Schuricht, Program Specialist, Children's Services, Bureau of Services for the Blind.

THE HABILITATION or rehabilitation of a blind child is most effective if the child is worked with at an early age. It is for this reason that the Ohio Rehabilitation Services Commission, through the Bureau of Services for the Blind, maintains a Children's Services Unit.

Birth to 16 years is the age range of children served by Children's Services Consultants. Within this range perhaps the most neglected years are from birth to 5 or 6 years, developmentally the most critical years of growth. The reasons for this are that few, if any, formal services are actually available and because the visual problems are not recognized or reported. By ages 5 or 6 the visual problem is recognized because of educational requirements and it is assumed the child will be worked with by the local school district.

When a child becomes known to a consultant he is eligible for a diversity of services depending upon individual need. Since the unit functions without case service funds or the ability to purchase service, everything offered must be on a personal basis.

For clarity the consultant's work can be divided into four areas.

First is work directly with the child. Such services would include instruction, counseling, and assistance in locating resources such as aids or appliances or camp.

Work with parents is second. This includes counseling with regard to the acceptance of a blind child, instruction in things to do with the child particularly in the areas of concept development, body image, spatial or environmental awareness and premobility skills. Also, the consultants would help find resources of various types such as written educational materials or rehabilitation programs in the local areas which may benefit the child.

Third, the consultants would work with agencies or other professionals. Such work would be centered on helping in the understanding of the problems of blindness, locating instructional resources and, if requested, training staff in procedures which would benefit the child.

Finally, the consultants are involved in public

relations; speaking engagements, case finding, and the general development of resources in their respective communities.

The physician who knows of a blind child, or any blind individual, is invited to contact the Bureau of Services for the Blind in his area, or have a member of the family make the contact.

Following are the area offices where contact may be made.

Mr. John Duran, Area Supervisor  
Miss Carol Krug, Children's Consultant  
400 Citizens Saving Building  
110 Central Plaza South  
Canton 44702  
Phone: 216-492-8894

Mr. Kenneth Kramer, Area Supervisor  
Miss Jane Teeters, Children's Consultant  
905 Enquirer Building  
617 Vine Street  
Cincinnati 45202  
Phone: 513-852-3223

Mr. Joseph Sullivan, Area Supervisor  
Miss Patricia Stone, Children's Consultant  
Second Federal Savings & Loan  
Association Building  
Suite 502  
335 Euclid Avenue  
Cleveland 44114  
Phone: 216-579-2930

Mr. Herman Reinke, Area Supervisor  
Mr. Neil Murphy, Children's Consultant  
Suite #316  
683 East Broad Street, Columbus 43215  
Phone: 614-469-7730

Mr. Philip Sekola, Area Supervisor  
Mrs. Melda Silberman, Children's Consultant  
604 Reibold Building  
117 South Main Street, Dayton 45402  
Phone: 513-228-6188

Mr. Joseph Stahl, Area Supervisor  
Miss Eileen Petric, Children's Consultant  
206 Joseph Building  
Dorr-Secor Shopping Center  
1450 Secor Road, Toledo 43607  
Phone: 419-536-8334

Mr. James Babb, Acting Area Supervisor  
401 Zwelling Building  
421-423 Main Street  
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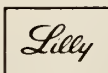
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NUMBER 2

## Clinical-Pathologic and Medicolegal Aspects of Coronary Artery Disease

GORDON K. MURPHY, M.D.

IT IS THE DUTY of the pathologist to be concerned not only with the study of disease itself, but always with the clinicopathologic correlation between the living patient and the evidence of disease he sees in the laboratory, under the microscope, and at the autopsy table. Nowhere is this more true than in the study of coronary artery disease, myocardial infarction, and sudden cardiac death. For here, the pathologist's gross and laboratory findings and his knowledge of the medico-legal implications of coronary disease may prove most helpful to the clinician in dealing with these challenging and often frustrating problems.

Having worked in both the autopsy and clinical pathology services at Miami Valley Hospital in Dayton, as well as in the Montgomery County (Ohio) Coroner's Office, I have felt that it would now be rewarding to review briefly for pathologists and clinicians alike the established pathology of coronary disease and sudden cardiac death, and to bring to their attention important recent developments in these areas.

In so doing, I shall concentrate my attention in three main areas.

1. Briefly, I shall review the nature, pathogenesis, and clinical presentation of atherosclerotic

### *The Author*

• Dr. Murphy, Baltimore, formerly Fourth Year Resident in Pathology, Miami Valley Hospital (Dayton), and Assistant Coroner for Montgomery County, is currently a Fellow in Forensic Pathology in the office of the Medical Examiner for the State of Maryland.

heart disease and myocardial infarction. With regard to diagnosis, I shall emphasize especially my recent study regarding the accuracy of our predicting acute myocardial infarction by electrocardiogram (EKG) in this hospital, as shown by analysis of EKG findings in autopsy-proven cases of acute myocardial infarction.

2. I shall discuss some of the newer biochemical and histopathologic technics available to the pathologist for detection of very early myocardial infarction at autopsy.

3. Finally, I shall consider the important subject of sudden unexpected cardiac death (SUCD). By using another recent study of mine (this one from the Montgomery County Coroner's Office), I shall reiterate some of the most important points

Submitted June 23, 1972.



regarding this entity. I shall mention some of its medicolegal implications, and shall comment on our accuracy of predicting SUCD in these cases from history alone, compared with figures established in autopsy-proven cases of SUCD in the Montgomery County Coroner's Office during the same period.

### Atherosclerotic Heart Disease

Just as heart disease is the leading cause of death in the United States, so coronary heart disease, especially the atherosclerotic type, is the chief form of fatal cardiac disease. A U. S. Government study in 1958 indicated that atherosclerotic heart disease was responsible for 78 percent of all cardiac deaths in white males, 66 percent in white females, and approximately 50 percent of these figures for nonwhites.<sup>1</sup>

Regarding the pathogenesis of atherosclerotic coronary artery disease, many constitutional, environmental, chemical, and histopathologic processes are felt to be contributory.

Predisposing factors are felt to include: disturbances of lipid metabolism (particularly significant are elevation of serum cholesterol and beta lipoprotein), obesity, diabetes mellitus, hypertension, emotional stress, familial factors, and cigarette smoking.

Investigation of the histopathologic sequence of the development of coronary atherosclerosis has yielded a generally accepted, but still somewhat controversial picture. Lipid seen beneath the intima of coronary arteries is felt by some to have been primarily deposited there. It is felt by others to have originated in the media of the vessels as a result of degenerative processes. Coronary atherosclerosis begins early in life; we see early atherosclerosis at autopsy in young children. Whatever the exact process involved in the development of atherosclerosis, the result is narrowing of the vessel lumen, the narrowing itself often being eventually responsible for cardiac disease and clinical symptoms. Necrosis in the intimal plaques, with "rupture" of lipid onto the intimal surface, provides a roughened endothelial surface which predisposes to superimposed coronary thrombosis and its associated problems.

Clinically, atherosclerotic coronary artery disease may be entirely asymptomatic, or it may become manifest in one or more of four general ways: (1) angina pectoris; (2) so-called "coronary insufficiency"; (3) myocardial infarction; and (4) sudden, unexpected cardiac death. Common to all of these is narrowing, or compromise of the coronary arterial lumen, with reduction of myocardial blood flow. The heart normally extracts about 60 to 70 percent of the available oxygen from the blood perfusing it. If the oxygen de-

mands of the myocardium are increased by tachycardia, increased systolic pressure, or increased inotropic effect, the heart must adjust to provide for them. It does so by two means: immediately, by a temporary shift to anaerobic metabolism or chronically, by the formation of additional, or collateral channels of flow. Pain is the primary symptom indicating that the heart cannot meet these increased demands for oxygen.<sup>2</sup> If they cannot be met, not only pain, but death of heart muscle (myocardial infarction) or even SUCD may result.

### Myocardial Infarction

This brings us now to the clinical entity of myocardial infarction. We are all familiar with the term, but what does it mean? I shall use it to mean irreversible anoxic damage to, and death of, cardiac muscle. It may be evident by clinical symptoms, clinical examination, laboratory tests, at autopsy, or by a combination of these means.

Just as the pathogenesis of myocardial infarction is not entirely clear, so the clinical and pathologic events during the evolution of myocardial infarction remain largely unknown. This is important, because the patient's symptoms and the resultant treatment are based upon these as yet incompletely understood events. One cannot study evolving myocardial ischemia or infarction at the metabolic level in living man. Experimental models are thus found in animals, particularly in dogs, where experimental occlusion or ligation of a coronary artery or arteries have been employed to induce acute myocardial infarction.

Oxygen deficiency is the primary cause of cell death in ischemic injury. The crucial event at the subcellular level seems to be damage to mitochondria, with inability of the cell to maintain its integrity. There is then increased cell membrane permeability, and leakage into the plasma of electrolytes and enzymes that signal anoxic damage. These may be helpful diagnostic indicators of acute myocardial infarction.

In the dog with experimental ligation of a coronary artery, EKG changes appear within eight to ten seconds after the onset of ischemia, with the switch to anerobic metabolism. In the dog, temporary coronary occlusion up to 18 minutes is survivable without demonstrable gross or microscopic evidence of myocardial cell death. After 20 minutes, the first irreversible changes are seen. At 40 minutes, about 50 percent of the cells in the involved area are dead, and at one hour, almost 100 percent are dead. What causes the changes actually to become irreversible is not known. This irreversible injury is detectable only by special technics in the first hour, but by six hours gross and light microscopic changes are evident. The

area of irreversible injury is then, by our usual pathologic technics, an acute myocardial infarction. It must be remembered that a myocardial infarction is a dynamic focus of changing metabolism and morphologic findings, which is never static until complete healing takes place.<sup>3</sup>

### Diagnosing Myocardial Infarction

The technics and the clinical art of diagnosing acute myocardial infarction are very familiar to most clinicians, so I shall comment only briefly on a few aspects of diagnosis.

Regarding clinical presentation, the identification of the high risk patient from clinical and laboratory data is a subject in itself. Significant factors include family history, lipid studies, the EKG (particularly with regard to certain ventricular arrhythmias), and evidence of cardiac enlargement. It has been noted by Knight that, "Any person with a heart in excess of 420 grams is at risk in the context of sudden death even where the coronary arteries are completely free from disease."<sup>4</sup> In a patient actually experiencing an acute myocardial infarction, it is not yet known whether the clinical onset of symptoms represents the moment when pathologic, metabolic, or EKG changes occur.

Studies of prodromal symptoms have shown that between 15 percent and 50 percent of patients hospitalized with acute myocardial infarction have characteristic prodromal symptoms, of which chest pain is by far the most common. Solomon found an incidence of 65 percent, the highest yet reported. We shall later see the sharp contrast between this figure and that seen with SUCD. It is felt by Solomon that not only the presence of angina, but a change in its pattern should be viewed with concern.

Regarding activity at the time of an acute myocardial infarction, he found that 23 percent of patients were in bed, 70 percent engaged in their usual activity, and only 5 percent in "unusual activity." In considering stress preceding acute myocardial infarction, he found a low incidence of unusual stress in the preceding weeks. This is in contrast to some other studies which have shown a high incidence of unusual stress, and it emphasizes the difficulty of evaluating environmental factors in myocardial infarction. Unfortunately, 50 percent of deaths from acute myocardial infarction take place before the subject can be hospitalized.<sup>5</sup> Death may be secondary to the infarction itself or to any of its several complications.

Regarding laboratory diagnosis, we are all familiar with the classical or typical enzyme patterns to be expected in a fully developed myocardial infarction. Serum glutamic oxaloacetic

transaminase, lactic dehydrogenase, and creatine phosphokinase are the enzymes most often used in diagnosing and evaluating acute and evolving myocardial infarction. Other enzymes relatively specific for heart muscle have been studied and employed, but are neither so consistently elevated nor so practical to determine. It should be emphasized that, depending on the extent of myocardial infarction, the time of sampling, and coexistent disease, enzymes may not be diagnostic. Other processes, such as congestive heart failure, liver disease, skeletal muscle damage, and pulmonary embolism, may cause enzyme elevations that may mimic or disguise those of myocardial infarction.

The EKG is perhaps the diagnostic modality most relied upon by many to establish or exclude the diagnosis of acute myocardial infarction. Fowler cautions, however, regarding the limitations of EKG findings. He states that, "While there is seldom no change in the EKG following acute myocardial infarction, the changes are often non-diagnostic, perhaps in as many as 40-50 percent of patients."<sup>6</sup> Zinn and Cosby, however, found diagnostic changes in about 80 percent of EKG's.<sup>7</sup> Hurst states that, ". . . careful studies of serial (EKG's) correlated with pathologic findings indicate . . . accuracy of diagnosis of acute infarction no more than 70-80 percent, and . . . likely less than 80 percent with old healed infarctions."<sup>8</sup>

The point regarding caution is well taken, for the EKG like any test is subject to errors in technic, artifacts, superimposed changes of other disease, and errors or uncertainties of interpretation. However, in the last year or two, there have been some rather spirited and heated discussions in this hospital between cardiologists and pathologists in particular, regarding the accuracy of the EKG vs that of the autopsy in the diagnosis of acute myocardial infarction. Let it suffice to say that there are limitations and pitfalls in both, and that false positive and false negative diagnoses may result. Diagnosis, therefore, must often be a co-operative venture. Let us look briefly at my recent study of this question, and then at some new pathologic technics for the early postmortem diagnosis of acute myocardial infarction.

### Postmortem Diagnosis

The case material was a series of 103 consecutive autopsy cases coded as "myocardial infarction" in the files of the Miami Valley Hospital Diagnostic Laboratories during the period from August 1968 through October 1971. Seventy-five of these cases were subsequently found suitable for further study, all having a gross and microscopic autopsy diagnosis of acute myocardial in-



farction. In making a final correlation between the clinical records of these patients, including EKG's, and the autopsy findings, 59 cases were found to have data sufficient for a valid correlation.

This consisted of (1) an autopsy diagnosis of acute myocardial infarction supported by both gross and microscopic findings, and (2) at least one EKG "positive" for acute myocardial infarction at any time during hospitalization or, if all EKG's were "negative," the final EKG having been run within 24 hours prior to death. The latter condition was imposed in order to deal with the potential objection that, in the case of a "false negative" EKG, an acute myocardial infarction perhaps "really" did occur some days or weeks antemortem, but no EKG was subsequently taken soon enough antemortem to demonstrate it.

A correlation was established in one of three categories as shown in Table 1, and the final results are as seen in Table 2. The total percentage of affirmative diagnoses of acute myocardial infarction (+ "positive" and  $\pm$  "suggestive") of 86 percent compares very favorably with that found in similar studies.<sup>6-8</sup> There were, on the other hand, undoubtedly more instances of "false positive" EKG diagnoses, but there was no practical way to retrieve these uncoded cases from the autopsy material.

It must be recognized that there are numerous factors in a patient with evolving myocardial infarction which may make the EKG diagnosis difficult or impossible. These include the location of the infarct (eg, posterior wall), and arrhythmias such as left bundle branch block (LBBB) and ventricular fibrillation (VFib). Table 3 lists figures regarding the EKG's run in all of the "false negative" cases. Study of the right-hand column reveals that all manifested in one or more EKG's,

TABLE 1. EKG-Autopsy Correlations

| EKG Readings   | Correlation |
|--|-------------|
| "A.M.I." or "consistent with"                                    | (+)         |
| Possible, suggests, probable, compatible with, consider "A.M.I." | ( $\pm$ )   |
| No mention of "A.M.I."   | false (—)   |

TABLE 2. Accuracy of EKG in Autopsy Proven-Acute Myocardial Infarction

| Correlation | No. of Cases | Total |
|-------------|--------------|-------|
| (+)         | 28           | 47.6% |
| ( $\pm$ )   | 23           | 38.9% |
| false (—)   | 8            | 13.5% |
|             | 59           |       |

Additional: False (+) EKG (read "A.M.I." without pathologic evidence of . . .) 2 cases.

TABLE 3. Details of "False Negative" EKG's

| Case No. | No. EKG's | No. Days | Last EKG Antemortem | EKG Diagnosis             |
|----------|-----------|----------|---------------------|---------------------------|
| 13       | 2         | 2        | Same day            | RBBB, LAD, 1° Blk, PVC's  |
| 41       | 1         | 1        | 30 min.             | A. Fib., LBBB, PVC's      |
| 46       | 4         | 5        | 1 day               | V. Fib. (terminal)        |
| 49       | 2         | 1        | 1½ hours            | V. Fib. (terminal)        |
| 55       | 1         | 3        | Uncertain           | V. Tachy., Idiov. Rhy.    |
| 66       | 5         | 3        | Same day            | Occ. PVC, V. Fib. (term.) |
| 71       | 2         | 14       | Same day            | LAD, V. Fib. (terminal)   |
| 75       | 6         | 23       | Agonal              | LBBB, V. Fib. (terminal)  |

A. Fib. = atrial fibrillation.  
1° Blk = first degree block.  
Idiov. Rhy. = idioventricular rhythm.  
LAD = left axis deviation.  
LBBB = left bundle branch block.  
PVC's = premature ventricular contractions.  
RBBB = right bundle branch block.  
V. Fib. = ventricular fibrillation.  
V. Tachy. = ventricular tachycardia.  
Occ. = occasional.

though not necessarily the final one antemortem, arrhythmia(s) which may have contributed to the cardiologist's failure to diagnose acute myocardial infarction from these tracings.

Of a series of 141 myocardial infarctions studied by Horn, 29 percent had coronary atherosclerosis only, 45 percent had coronary thrombosis, and 39 percent mural hemorrhage, the latter two usually superimposed on severe atherosclerosis.<sup>9</sup> In general, those patients with thrombosis characteristically have unifocal, transmural infarction, while those with atherosclerosis only have multifocal and (or) subendocardial infarction.

It is instructive in this regard to refer again to my autopsy-EKG study, and to make a further correlation, this between the coronary lesion and infarct found at autopsy, and the accuracy of diagnosis by EKG.

It will be seen from Table 4 that of those cases positively (+) diagnosed by EKG, approximately two thirds had recent coronary thrombosis and, usually, a unifocal, transmural myocardial infarction. Exactly the opposite pertained with regard to the "suggestive" ( $\pm$ ) and "false negative" groups, where only about one third had recent coronary thrombosis and transmural infarction, and about two thirds had nonthrombotic coronary artery disease and patchy, often multifocal, subendocardial myocardial infarction.

The conclusion to be drawn is perhaps an obvious one, but nevertheless it bears reemphasis. The acute myocardial infarction most readily diagnosed by EKG is one in which there is a recent coronary thrombosis, with complete or near-complete luminal occlusion and transmural death of cardiac muscle in a well-defined area. Those cases with superficial, multifocal ischemic changes



due to severe coronary disease only are diagnosed with considerably more difficulty.

The overall percentage of thrombotic vs non-thrombotic coronary disease is also instructive, for the percentage of thrombosis in this study is considerably higher than that found in the SUCD's listed below. This considerable difference will be further emphasized later. The increased incidence of coronary thrombosis with increased length of survival has been noted also in other studies, and is alluded to by some who believe that thrombosis is very often an event secondary to acute myocardial infarction and reduced coronary flow, rather than the primary event in initiating infarction.<sup>2</sup>

The morphologic identification of the earliest stages of myocardial ischemia and myocardial infarction at autopsy remains a pressing challenge to the pathologist,<sup>10</sup> and particularly to the forensic or coroner's pathologist. Sudden death can result from myocardial ischemia. If death is rapid, an early infarct may not be demonstrable at autopsy. Its presence can be presumed from circumstantial evidence only. Caution is necessary, however, for the presence of fresh thrombus does not prove coexistent myocardial infarction, or vice versa.<sup>11</sup>

At autopsy, gross changes of myocardial infarction will not be seen for 12 to 20 hours after the onset of irreversible changes in the myocardium, though diagnostic microscopic changes may be apparent in six to eight hours. We need, therefore, a simple, rapid, reliable histological or histochemical technic, not affected by postmortem autolysis, to show acute myocardial infarction in its earliest phases.<sup>10</sup> This need is particularly vital in medicolegal cases, where the demonstration of an early infarction, especially in the presence of less-than-severe coronary disease, along with the history may be of vital importance in ruling cause and manner of death. It may make the difference between a ruling of "natural" vs "accidental," "natural" vs "homicide," or "natural" vs "therapeutic misadventure." The latter question might arise in a death during or after anesthesia

and surgery, where the demonstration of an occult, early, preoperative myocardial infarction might be of vital importance.

Zugibe reported a method for the detection of very early myocardial infarction utilizing changes in the ionic ratio of potassium and sodium in myocardial cells. The normal intracellular potassium/sodium ratio is usually 1.1 or more/1.0. With anoxic damage, however, potassium leaks out and sodium moves in, lowering the ratio. This process occurs normally during electrical depolarization of the cell, but normally the ratio is quickly restored by the so-called "sodium pump." Experiments in dogs with coronary artery occlusion induced experimentally showed in 40 percent, changes in ionic balance detectable by biochemical technics as early as ten minutes after the onset of ischemia. Such studies are performed by homogenizing the muscle in de-ionized water, centrifuging, and analyzing the supernatant for the ions. With myocardial infarction, the ratio of potassium/sodium will drop to 0.7 or less/1.0. It is extremely useful for at least the first 24 hours of infarction, and is not affected by autolysis. But, since there are no gross clues as to which areas of myocardium to sample, the method is subject to sampling error.<sup>12</sup>

The myocardium is very rich in enzymes, which catalyze the normal aerobic metabolism of the myocardium to produce energy from carbohydrate. Particularly important and abundant are the dehydrogenases, though they are not specific for myocardium. Various macro- and micro-enzyme technics utilize specific strains for enzymes, on the premise that ischemic or dead myocardial cells will have lost enzymes, and will not take the enzyme stains, while intact, viable cells will. An example is the Nitro BT stain for dehydrogenases (eg. malate and succinic dehydrogenases). The technics are relatively rapid, involving application of stain to a gross slice of heart muscle at autopsy, incubation, and gross evaluation of the result. They are, however, extremely susceptible to autolysis, particularly with regard to staining for lactic

TABLE 4. Coronary Lesion-Infarct and Accuracy of EKG

| Correlation   | Recent Thrombosis<br>(Transmural Myocardial Infarction)<br>(%) | ASHD-Nonthrombotic<br>(Subendocardial Myocardial Infarction)<br>(%) | Embolus Vegetation<br>(Mitral Prosthesis)<br>(%) |
|---|--|---|--|
| (+)   | 60.7   | 35.7  | 3.6  |
| (±)   | 30.5   | 69.5  | —  |
| False (—)   | 37.5   | 62.5  | —  |
| Total   | 45.8   | 52.5  | 1.7  |
| SUCD generally<br>accepted figures  | 20.0   | 80.0  |  |
| 25 autopsies, Montgomery County<br>Coroner's Office, 1971 (14 Cor.<br>Dis. and 11 A.M.I.) | 28.0   | 72.0  |  |

dehydrogenase. Sampling error is also a consideration. The technics are useful for two to four days after the onset of infarction, but require normal heart muscle as a control.<sup>11</sup>

A new enzyme technic with great promise is the HBFP stain (hematoxylin-basic fuchsin-picric acid). It is a selective stain for early ischemic myocardium or skeletal muscle, but stains neither normal nor grossly infarcted (necrotic) muscle.

The tissue is fixed in formalin, paraffin sections are made, and the tissue then stained first with alum hematoxylin (a mordant), then with basic fuchsin, and finally decolorized with picric acid-acetone solution. There are a few critical procedural and technical details, particularly the length of the decolorization step.

Normal myocardium with decolorization loses its affinity for basic fuchsin, and takes the light brown stain of picric acid. Ischemic myocardium is not decolorized, and stains with brilliant red basic fuchsin as early as 30 minutes after the onset of irreversible anoxia. After six hours the number of fibers staining begins to decrease, and continues to decrease with necrosis and repair. This stain shows well early ischemic changes undetectable by other methods, and ischemic areas ("extension") at the periphery of an older infarction. Early results with the HBFP stain in our laboratory have been most satisfactory.

There are also more specialized stains for other substances indicative of ischemic myocardial damage. These include immunofluorescent microscopic stains for immune gamma globulin, intracellular C-reactive protein, and fibrinogen. They are, however, presently suited only for research work.<sup>10</sup>

### Sudden Unexpected Cardiac Death

Fowler defines sudden death as, "... that which occurs unexpectedly and from natural causes in a person who was previously in apparent good health." About 10 to 15 percent of all deaths in the United States are sudden, unexpected natural deaths,<sup>6</sup> and many come under the jurisdiction of the coroner or medical examiner. The great majority of these deaths are a result of coronary disease, as are virtually all of the instantaneous ones. The common denominator in all is significant coronary artery disease, usually atherosclerosis, but not necessarily myocardial infarction. There is terminal hypoxia, usually secondary to a cardiac arrhythmia or, less often, to myocardial infarction.<sup>2</sup> With myocardial infarction, severe occlusive coronary artery disease is found most often, then thrombosis in a considerably smaller number of patients.

While it is popularly thought that sudden cardiac death often results from "coronary throm-

bosis," fresh thrombi are found in only about 20 percent of SUCD's, and occlusive atherosclerosis only in about 80 percent.<sup>13</sup> A correspondingly low percentage of SUCD's have myocardial infarction demonstrable by our present methods. The great majority do not have myocardial infarction.

It surprises many to learn, or to realize, that sudden death from coronary artery disease is often the first and only sign of its presence, there apparently having been no prodromata. Myerburg, in a series of 1,348 SUCD's, found that only 26 percent had known coronary disease, 33 percent had undiagnosed symptoms, and that in 41 percent, SUCD was the first and only sign of coronary artery disease.<sup>14</sup>

The Framingham Study revealed that 50 percent of SUCD's had no previous clinical evidence of coronary heart disease.<sup>15</sup> Many such individuals have had recent physical examinations, EKG's, and other tests, and have been pronounced in good health. This again emphasizes the limitations of our present diagnostic methods.

Studies of activity being engaged in by these individuals at the time of SUCD are very interesting, and are again at variance with the impressions of many regarding the relationship of emotion and exertion to SUCD. Spain reported that only 2.2 percent of SUCD's were engaging in anything but normal activity; the overwhelming majority died at home.<sup>16</sup>

Apart from the fact of death per se, SUCD has vital medicolegal implications. Especially in the previously asymptomatic patient, establishing a ruling of "natural" rather than "suicide" or "accident," and particularly when death occurs in a questionable setting, may be of great importance. When sudden death occurs in a driver at the wheel of an automobile or while piloting an airplane, others may also be killed or injured. The demonstration of an acute, natural cardiac death, rather than negligence or accident, is again of great potential importance. The public interest was also served when the post-crash autopsy of an airline pilot disclosed a SUCD, and brought to light failure to report preexisting cardiac disease to aviation medical examiners. It led thus to more stringent enforcement of medical investigation and reporting procedures for aircraft crews.<sup>17</sup>

In the Montgomery County Coroner's Office, we do not perform autopsies on the vast majority of apparently natural deaths in adults, because of lack of authority and limitations of time and personnel. These cases are termed "sign-outs." In such cases, a trained investigator takes a medical history, if possible from both the attending physician and the family. The body is brought to the coroner's morgue, where the pathologist evaluates the history, requesting additional information if necessary, and makes a detailed



external examination of the body. If there is nothing to indicate other than a natural cause of death, the death certificate is "signed out," without an autopsy, usually as "acute myocardial failure, secondary to degenerative cardiovascular disease."

I have wondered in the past if we are not over-diagnosing SUCD by history and inspection alone. Thus, I have performed a study of all of our "sign-outs" in 1971, and of all of our autopsy-proven SUCD's in the same period, comparing the respective figures with two objects in mind. They were (1) to compare our figures in SUCD "sign-outs" with those from other studies, and (2) to determine if the "sign-out" diagnosis is being abused.

Table 5 details in horizontal headings the circumstances in which the subjects were found and, on the vertical axis, the cardiac history as percentages of all those in which such history could be obtained. The percentage of those with a history of past cardiac disease and (or) symptoms is small in comparison with that found by Solomon in his group of patients hospitalized with myocardial infarction.<sup>5</sup> It is also obvious that only a very small number (2 percent) of these individuals died suddenly during strenuous exercise (usually active sports). Of those dying during moderate exercise, ranging from carrying out trash to driving a car, 41 percent had no history of previous cardiac disease, SUCD being apparently the first and only evidence of cardiac disease. The figure is identical to that previously cited from Myerburg.<sup>14</sup> Of those found at home or dead on arrival, a moderate-to-large number had a history of previous coronary heart disease or symptoms.

In Table 6, it may be seen that there is in general a close correlation between the circum-

stances in SUCD as determined by coroner's autopsies, and those found in a large number of cases ("sign-outs") assigned the postmortem diagnosis of SUCD after historical and external examination alone. The correlation in the "died in sleep" and "mild-moderate exercise" categories are poorer because of the natural inclination of the pathologist for various reasons not to perform, and to perform an autopsy, respectively, in these two sets of circumstances.

Thus, it is my conclusion that the "sign-out" diagnosis of SUCD is not being abused but rather, that this diagnosis is being made with considerable accuracy in most cases from a careful history and external examination of the body alone. Nevertheless, an autopsy is still preferable if doubt exists regarding the cause and manner of death, and if there are no medicolegal contraindications.

The problems of coronary heart disease, myocardial infarction, and sudden cardiac death are closely interrelated and multifaceted ones. Their study and solution require the cooperation of the clinician, cardiologist, pathologist, and epidemiologist. New technics for their study include: case-finding and identification; new diagnostic tools such as angiography, lipid studies, and cardiac catheterization; mobile and hospital coronary care units; monitors; and coronary bypass surgery. Hopefully, by employing these technics in conjunction with the pathologist's diagnostic methods, we can further elucidate and help to solve these most pressing of medical problems.

Summary

The pathologist has the opportunity to make vital clinicopathologic correlations in the complex

TABLE 5. History and Circumstances of Sudden Cardiac Deaths, Montgomery County Coroner's Office in 1971 from 356 "Signouts," of which 248 (70%) were "AMF-DCVD"

|                             | Found "Soon"<br>(Minutes/Few Hours)<br>After Seen Alive | Died in<br>Sleep | Dead on<br>Arrival | Sudden<br>Collapse | Collapse<br>During Mild<br>to Moderate<br>Exertion | Collapse<br>During<br>Strenuous<br>Exertion | Found<br>After<br>Hours-<br>Days |
|-----------------------------|---|------------------|--------------------|--------------------|--|---|----------------------------------|
| Those with definite history | 27%   | 18%              | 15%                | 19%                | 12%  | 2%  | 7%                               |
| No symptoms                 | 14  | 24               | 3                  | 11                 | 41   | 0   | 100                              |
| History ASHD                | 59  | 38               | 30                 | 25                 | 30   | 0   | 0                                |
| History recent symptoms     | 17  | 38               | 61                 | 46                 | 17   | 100   | 0                                |
| History and symptoms        | 10  | 0                | 6                  | 18                 | 12   | 0   | 0                                |

TABLE 6. Accuracy of "Signouts" (SO) vs. Autopsies—"Sudden Unexpected Cardiac Death" (SUCD), Montgomery County Coroner's Office 1971

|                 | "Found<br>Soon"<br>(%) | Died in<br>Sleep<br>(%) | Dead on<br>Arrival<br>(%) | Sudden<br>Collapse<br>(%) | Mild to<br>Moderate<br>Exertion<br>(%) | Strenuous<br>Exertion<br>(%) | "Found<br>Later"<br>(%) |
|-----------------|------------------------|-------------------------|---------------------------|---------------------------|--|------------------------------|-------------------------|
| 248 SO's (SUCD) | 27                     | 18                      | 15                        | 19                        | 12                                     | 2                            | 7                       |
| 25 Autopsies    | 28                     | 4                       | 12                        | 20                        | 24                                     | 8                            | 4                       |



and pressing problems of coronary heart disease, myocardial infarction, and sudden unexpected cardiac death. Coronary heart disease is the leading cause of cardiac death in the United States. Its pathogenesis is complex, and its eventual effect is often progressive myocardial ischemia, with death of heart muscle (myocardial infarction). Diagnosis must often be a cooperative effort between clinician and pathologist. The EKG is an important diagnostic modality, with generally a high rate of accuracy in the diagnosis of acute myocardial infarction. New histochemical and microscopic technics may be of great assistance to the pathologist in diagnosing early myocardial infarction inapparent by the usual means. Sudden unexpected cardiac death is a common and vexing problem, which has vital medicolegal implications. Many patients so affected were previously asymptomatic. Sudden cardiac death may be diagnosed postmortem with considerable accuracy from a searching history and external examination of the body alone, but autopsy confirmation is preferable whenever possible.

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**RED CELL SODIUM IN HYPERTHYROIDISM.** — A simple method of measuring red cell sodium has shown that about 90 percent of thyrotoxic patients have values above the upper limit of the normal range. Patients taking 0.3 mg of L-thyroxine daily were found to have a significantly higher mean value for red cell sodium than that of the normal controls. It is suggested that patients taking this amount of thyroxine may be hypermetabolic. The determination of red cell sodium may prove useful as a measure of the peripheral action of thyroid hormone. — A. W. G. Goolden, M.B.; Diana Bateman; and Susan Torr, B.Sc., London: *British Medical Journal*, 2:552-554, June 5, 1971.

# Sustained Isometric Handgrip

## A Useful Bedside Maneuver

NALLAN C. RAMAKRISHNA, M.D.\*

THE ADVENT OF EACH new cardiovascular diagnostic technic has led to a broadened foundation for verification and refinement of the technic of physical examination enabling the astute physician to use physiologic principles to enhance his diagnostic acumen. Thus, for example, cardiac catheterization has helped to define the relationships between variations of splitting of the second heart sound and intracardiac pressures. Recognition and characterization of wall motion disorders with the radarkymogram, with isotope angiocardiograms, and with left ventricular cineangiograms has facilitated clinical detection of dyskinesia in patients with acute myocardial infarction and hence provided the clinician with an additional important diagnostic sign of this disorder.

In part as an outgrowth of exercise testing and pharmacologic stress testing of the cardiovascular system, a new technic, isometric handgrip, has been used to enhance further the value of physical examination of the heart. Isometric handgrip, a simple bedside physiologic stress test, can be used to characterize and differentiate the origin of several murmurs and to detect impaired ventricular performance.

Sustained isometric handgrip promptly elevates systematic arterial pressure, increases heart rate, and augments cardiac output. These changes regress quickly when handgrip is released. The physiologic response to sustained isometric handgrip appears to be mediated by reflex mechanisms. Resulting changes in the peripheral vascular resistance impose an acute stress on the left ventricle by increasing afterload.

The test is performed with the use of a commercially available Handgrip Dynamometer. The patient is asked to squeeze the dynamometer with the maximum force he can exert. After the extent of maximum voluntary contraction has been determined and the patient has rested, he is then

instructed to initiate and maintain handgrip at 25 to 50 percent of the maximal force for a period of two to three minutes. Graphic recordings of heart sounds, the electrocardiogram, or hemodynamic measurements can be obtained to supplement auscultation performed during the interval in which handgrip is sustained. When a dynamometer is not available, the test can be performed by asking the patient to squeeze the examiner's hand for the desired interval.

Although the test is safe, caution should be exercised when it is used in patients with coronary artery disease. The acute stress imposed can lead to the precipitation of angina or serious arrhythmias. Hence, testing such patients should be performed with concomitant monitoring of the electrocardiogram and emergency equipment should be available for correction of serious arrhythmias.

Isometric handgrip is helpful in differentiating systolic murmurs of aortic and mitral origin. The murmur of aortic stenosis becomes less intense because the gradient across the aortic valve is reduced. In contrast, the holosystolic murmur of mitral regurgitation increases in intensity due to the increase in regurgitation secondary to increased afterload.

In patients with the prolapsing posterior mitral leaflet syndrome (click-murmur syndrome), the late systolic murmur may be elicited by isometric handgrip. If the murmur is already present at rest, it may intensify, and its duration may be prolonged by this maneuver. In patients with this syndrome, the click often moves nearer to the first heart sound during isometric handgrip.

Handgrip increases the intensity of the diastolic murmur of aortic regurgitation. Hence, it is useful in distinguishing aortic regurgitant murmurs from pulmonic regurgitant murmurs, which are not altered by handgrip.

Handgrip may intensify the diastolic rumble of mitral stenosis because tachycardia reduces filling time and therefore the pressure gradient across the mitral valve increases.

Sustained isometric handgrip is helpful in distinguishing the Austin Flint murmur associated with aortic regurgitation from the presystolic

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rumble of mitral stenosis. The Austin Flint murmur in patients with moderately severe aortic regurgitation is presystolic in timing. As regurgitation becomes severe, the murmur becomes mid-diastolic due to the increase of left ventricular end diastolic pressure resulting in closure of the mitral valve before the end of the diastolic period. Thus, with the hand grip test, the presystolic murmur of the Austin Flint type shifts to mid-diastole in contrast to the murmur of mitral stenosis, which becomes louder without change in timing.

In patients with either ischemic heart disease or primary myocardial disease, atrial or ventricular gallops which may be absent at rest can be elicited

by isometric handgrip. The acute stress induced by the maneuver results in the production of filling sounds, ie, the atrial and/or ventricular gallops, because of decreased ventricular compliance.

### Summary

Isometric handgrip is a simple diagnostic maneuver which can provide useful information at the bedside and in the diagnostic laboratory. It is of value in detecting valvular and myocardial disease and in elucidating their nature and extent. It represents an excellent example of the application of physiologic principles in the clinical setting to improve cardiovascular diagnosis.

## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

This 20-year-old man was struck in the nose four hours before he was brought to your office. There is only slight swelling over his nasal bridge, but he has complete nasal obstruction due to two soft red masses which fill each side of his nose (Fig. 1).

X-ray films reveal a linear, nondisplaced fracture of the right nasal bone.

What is your diagnosis and how should this be treated?

*(See p. 129 of this issue for further information and discussion.)*

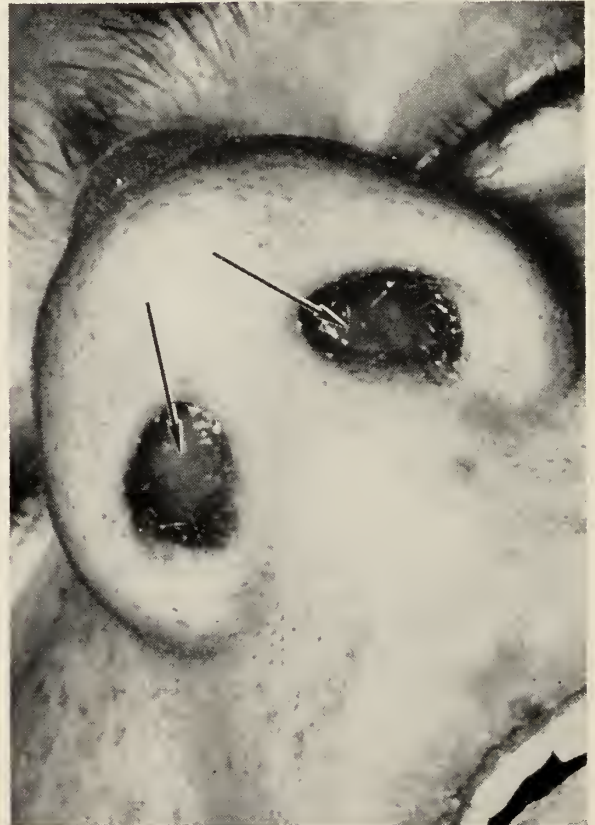


FIG. 1. Nasal obstruction is due to two soft red masses (arrows).

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Submitted March 28, 1972.



# Clinical Application of Two New Noninvasive Cardiovascular Technics

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**R**ELIABLE, NONINVASIVE METHODS for cardiovascular evaluation are of increasing value. Recently two such technics have been developed which are useful in the management of acutely ill patients:

1. The Doppler ultrasonic flowmeter for measurement of blood pressure and,
2. Radarkymography for evaluating cardiac wall motion.

## The Doppler Ultrasonic Flowmeter in Blood Pressure Measurement

Briefly, this system consists of a transducer with two piezo-electric crystals. The transducer is placed on the skin overlying an artery. One crystal emits a 10-megacycle sound through the arterial wall into the blood stream, the other records ultrasound reflected by moving red cells. Since the red cells are in motion, the frequency of the reflected sound differs from that of the emitted sound and the difference is proportional to red cell velocity [hence blood flow].

To measure blood pressure the Doppler transducer is placed over the radial artery. Proximal to this, flow is interrupted at the level of the brachial artery with a conventional blood pressure inflatable cuff. The pressure in the cuff is recorded simultaneously with the Doppler signal. When cuff pressure exceeds systolic pressure, blood flow in the underlying artery ceases and no Doppler signal is recorded. Gradual deflation of the cuff causes a drop in cuff pressure until at systolic arterial pressure the vessel opens partially and blood flow

commences. Thus, ultrasound hits *moving* red cells and the first signal is heard. The level of the pressure in the cuff at which the first signal is noted records the level of the systolic blood pressure. As the cuff is further deflated a point is reached when the flow in the underlying artery becomes continuous. That level of cuff pressure at which the flow becomes continuous, diastolic pressure, is apparent on the Doppler signal recordings as the signal that remains above zero throughout systole and diastole.

When systolic blood pressure determinations with the Doppler flowmeter are compared with intra-arterial values, results are closely correlated. Over a wide range of systolic arterial pressures (48 to 144 mm Hg) in 65 measurements, the correlation coefficient was 0.99, and the maximum difference in values obtained with the Doppler method were 4 mm Hg above and 10 mm Hg below values obtained with the direct method.

When diastolic measurements are obtainable and compared with those obtained with the intra-arterial needle the correlation is also excellent. Over a wide range of pressures (34 to 88 mm Hg), the correlation coefficient was 0.95, and the average difference between the two methods was 1.8 mm Hg.

The Doppler ultrasonic method for blood pressure determination has been of greatest clinical value in monitoring blood pressure accurately and atraumatically in acutely ill patients such as those in shock. Accurate Doppler measurements were obtained even when blood pressure could not be assessed conventionally by palpation or auscultation because of severe vasoconstriction. In addition to its accuracy, the Doppler method has the advantage of providing a signal which can be telemetered, recorded and made audible at the bedside. It tends to obviate observer bias, known to

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influence apparent blood pressure measurements by sphygmomanometry at lower levels of pressure.

The Doppler ultrasound method has been of value recently in analyzing the pulse contour of patients with myocardial or pericardial disease. In three patients with left ventricular dysfunction, pulsus alternans was successfully recorded, whereas in two other patients with pericardial disease, pulsus paradoxus was recorded. The Doppler method is useful in infants and in obese subjects in whom conventional methods may be inapplicable. In addition, it is of considerable value in evaluating blood pressure and flow in the lower extremities of patients with arterial occlusive disease both before and after reconstructive surgery.

### Radarkymography in Evaluating Left Ventricular Wall Motion

Radarkymography is an electronic process by which the pulsations of the cardiac silhouette, visualized on a television screen, can be recorded reliably. The radarkymograph utilizes a radar loop similar to the one used to track missiles. The fluoroscopic image of the heart is projected on a television screen. As the heart pulsates, the image of the cardiac border presents a constant transition from dark to light (the cardiac silhouette being more opaque than the adjacent lung). This transition is translated into a voltage peak onto which an electronic tracker locks and follows the image of the heart. As the heart contracts in systole, the image of the lateral wall of the left ventricle moves medially. This motion is translated into an analog signal as a downward deflection (S wave). During ventricular filling in diastole, the wall of the left ventricle moves laterally. This lateral motion is recorded as an upward deflection (D wave). At the beginning of ventricular systole, the heart rotates and the shape of the left ventricle changes to a more spherical one. This creates an initial outward motion of the left ventricle, and it is recorded as an initial upward wave (A wave). Thus, during a cardiac cycle three distinct waves are recorded: the A, S, and D waves. The electrocardiogram is used as a reference tracing. When the radarkymograph tracker is positioned on selected parts of the silhouette, cardiac pulsations can be recorded from specific portions of the heart and great vessels. During ventricular systole the ejected blood distends the aorta which moves laterally; this movement is recorded as an upward deflection on the radarkymogram. During diastole when the aortic wall moves medially, the radarkymogram records a downward deflection. Tracings from sites of myocardial injury often reveal paradoxical pulsation. Thus, the radarkymogram shows complete reversal of the direction of the waves in systole and diastole.

Since left ventricular wall motion abnormalities interfere with normal cardiac function and

may be an important cause of heart failure, their detection and localization are important. When 32 patients with chronic coronary artery disease with or without *old* myocardial infarction were studied, paradoxical pulsations were demonstrated in 89 percent. In contrast, fluoroscopy (a technic widely used to localize asynergism of contraction of the left ventricular wall) detected asynergistic areas in only 61 percent.

Radarkymography has been of greatest practical value in the diagnosis and follow-up of patients with acute myocardial infarction. Paradoxical pulsations of the infarcted myocardial wall are often detectable on the radarkymogram within 30 minutes after the onset of symptoms, and localization of the involved area of the heart is often possible.

In 34 of 45 patients (76 percent) with acute myocardial infarction, paradoxical pulsations of the left ventricular wall were recorded by means of radarkymography. These abnormalities were followed serially for periods up to 16 months. Of the 34 patients who originally demonstrated paradoxical pulsation, ten (30 percent) died within 24 hours to 6 months after acute myocardial infarction, 14 (41 percent) retained paradoxical pulsation, three showed akinesis, three showed hypokinesis, and four regained normal pulsations. Of the 15 patients in whom paradoxical pulsations were either never present or in whom paradoxical pulsations disappeared during the follow-up period, only one patient died. Thus, radarkymography is not only of clinical importance in detecting wall-motion disorder in coronary artery disease, but it also serves as a prognostic index. It is superior to standard fluoroscopy if only because it is more independent of subjective interpretation. Furthermore, since it is noninvasive, it is easily adaptable to acutely ill patients such as those with acute myocardial infarction.

### Summary

The Doppler ultrasonic flowmeter is an effective and reliable atraumatic device by which blood pressure determinations can be obtained accurately. Its signal can be made audible and used to monitor acutely ill patients continuously. It can be readily applied to localize arterial occlusive disease.

Radarkymography is a noninvasive technic by which asynergistic areas of the left ventricular wall can be detected with accuracy. It is of clinical value in detecting wall-motion abnormalities in patients with acute myocardial infarction and coronary artery disease. Since such abnormalities may contribute to the development of heart failure and persistent angina, their detection and evaluation are of considerable importance.

# Clinical Applications of the Carotid Sinus Reflex

STEPHEN F. VATNER, M.D.\*

FOR THE PAST HALF CENTURY, the carotid sinus reflex has been the focus of intense physiologic interest and investigation. This fundamental cardiovascular reflex influences and regulates arterial pressure, heart rate, myocardial contractility, and peripheral vascular resistance. Recently, exogenous stimulation of this reflex has been employed as a diagnostic and therapeutic tool.

The carotid sinus is a dilatation of the internal carotid artery near its origin at the bifurcation of the common carotid artery. Afferent information from the carotid sinus is relayed to the cardiovascular centers in the brainstem via the carotid sinus nerve, a branch of the glossopharyngeal. The efferent loop of the carotid sinus reflex comprises both sympathetic and parasympathetic pathways to the heart which influence heart rate and myocardial contractility and sympathetic pathways to the adrenal medulla and the peripheral arterial and venous vasculature. The reflex functions as a negative feedback system, ie, an increase in arterial pressure increases afferent nerve traffic to the cardiovascular center, which in turn reflexly reduces peripheral vascular resistance, heart rate, myocardial contractility, and circulating catecholamines; all of which tend to return arterial pressure to control. Carotid sinus hypotension produces opposite results. A similar reflex arises from a pressure-sensing mechanism located in the aortic arch. These reflexes comprise the major barore-

ceptor systems. The baroreceptors serve to maintain arterial pressure and cardiovascular dynamics relatively constant.

Excessive activation of the carotid sinus reflex may produce carotid sinus syncope. Susceptible patients with a hyperactive carotid sinus reflex are therefore prone to episodic hypotension and syncope; characteristically in elderly men, especially those who wear high, tight collars, and young women just prior to menstruation. Patients afflicted with Takayasu's syndrome, a nonspecific arteritis affecting the subclavian and carotid arteries of young women, are susceptible to carotid sinus syncope.

One established therapeutic and diagnostic maneuver involving the carotid sinus is differentiation of supraventricular from ventricular arrhythmias and the interruption of paroxysmal atrial tachycardia by manual carotid sinus massage. Massage simulates arterial hypertension and results in a reduction of sympathetic tone and a simultaneous increase in vagal tone to the heart. Thus, automaticity decreases, conduction slows, and the tachycardia is frequently abruptly terminated.

Carotid sinus massage has several potential pitfalls. The technic cannot be applied to all patients since carotid blood flow may be compromised in the presence of coexisting cerebral vascular disease. Syncope, cardiac standstill due to excessive vagal inhibition of the sino-atrial or AV nodes, dislocation of an arterial thrombus or plaque with consequent cerebral embolism are potential risks that can be minimized by careful monitoring of heart rate and limitation of duration of compression.

The carotid sinus nerves can be activated by a new technic now used for interrupting disabling,

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recurrent attacks of paroxysmal atrial tachycardia. The baroreflex is activated by electrical stimulation of the carotid sinus nerves, again, like manual stimulation, stimulating the afferent limb of the reflex arc and tending to slow the heart rate and interrupt the attack by decreasing sympathetic tone and increasing in vagal restraint. At operation, electrodes are implanted bilaterally on the carotid sinus nerves and a radiofrequency receiver attached to the electrodes is placed in a subcutaneous pocket. After the recovery from operation, the patient activates a radiofrequency pacemaker\* to stimulate the carotid sinus nerves electrically via the receiver-electrode circuit. Thus, the reflex can be activated immediately by the patient as needed, stimulation can be discontinued abruptly, and stimulation may be initiated safely and repeatedly.

Carotid sinus massage has been used as a tool in the diagnosis of angina pectoris for many years. Recently carotid sinus nerve stimulation has been employed also in the therapy of angina pectoris by Braunwald and co-workers. Angina pectoris results from a disparity between the oxygen requirements of the myocardium and oxygen availability via myocardial blood supply. Electrical stimulation of the carotid sinus nerves tends to diminish the myocardial oxygen requirements primarily by reducing arterial pressure, left ventricular afterload, and myocardial wall tension, while it reduces heart rate and myocardial contractility to a lesser extent. In addition, carotid sinus nerve stimulation produces reflex coronary vasodilatation through a reduction in resting sympathetic coronary constrictor tone. The reduction in myocardial oxygen requirements and possibly increased supply has proved to be beneficial to patients using electrical carotid stimulation to terminate attacks of angina pectoris.

Since the main function of the carotid sinus reflex is to regulate arterial pressure, carotid sinus nerve stimulation has been used in the therapy of the most common disorder of blood pressure,

essential hypertension. Altered function of this reflex may contribute to sustained hypertension in this disorder. Persistent electrical carotid sinus stimulation has lowered blood pressure substantially for as long as five years. In some cases, actual regression of eyeground changes has occurred. This technic, in association with antihypertensive drug therapy, is being used successfully for the treatment of moderate and severe hypertension.

Activation of the carotid sinus reflex is a useful diagnostic tool. Experiments in animals by Vatner and associates have demonstrated that the characteristics of the reflex change with altered states of consciousness, ie, a differential pattern of autonomic outflow, occurs in the conscious organism as opposed to during sleep or after general anesthesia. Baroreceptor function can be assessed in man by measurement of heart rate after administration of angiotensin intravenously. This drug raises arterial pressure by increasing peripheral resistance. The elevated arterial pressure then causes reflex slowing of heart rate. The relationship between the rise in arterial pressure and reflex slowing has been characterized in normal individuals and has been found to be altered in patients with hypertension and those with congestive heart failure. Diminished baroreceptor sensitivity has been demonstrated in both these disease states and may contribute to maintenance of essential hypertension.

### Summary

The carotid sinus reflex, a cornerstone of cardiovascular physiology for half a century, is now being utilized in cardiovascular diagnosis and therapy. Electrical stimulation of the carotid sinus nerve is being employed to treat angina pectoris, recurrent supraventricular tachycardia, and essential hypertension. In addition, altered responsiveness of the baroreceptors in disease states may be valuable diagnostically and may provide further understanding of the pathophysiology of several circulatory disturbances.

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\*Medtronic, Inc., Minneapolis, Minnesota

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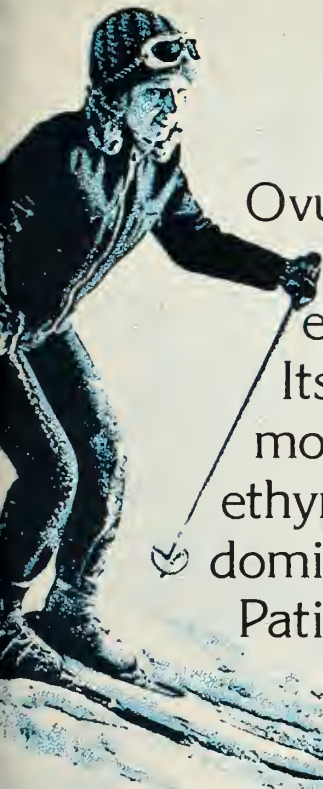
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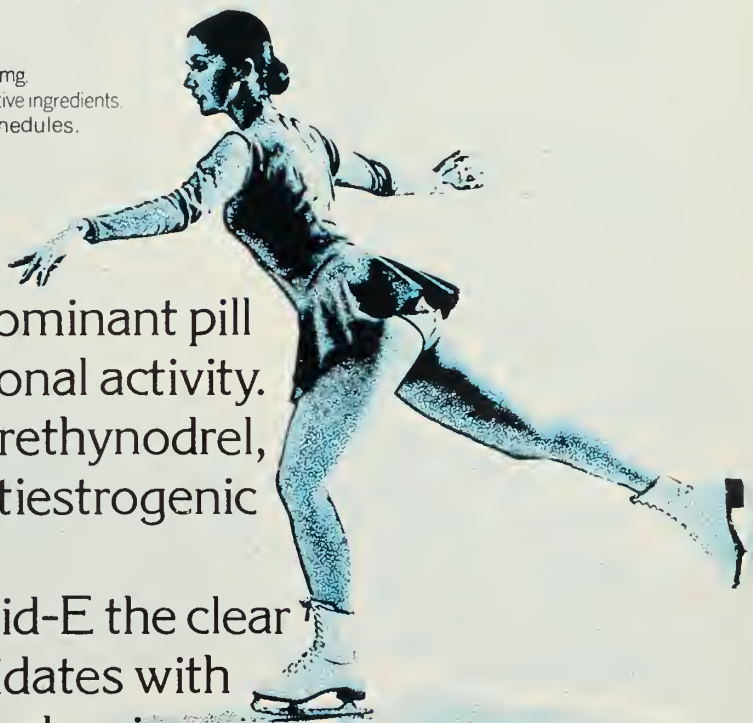
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**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in sub-primate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>1</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and

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the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function, increased sulfobromophthalein retention and other tests; coagulation tests, increase in prothrombin, Factors VII, VIII, IX and X, thyroid function, increase in PBI and butanol extractable protein bound iodine, and decrease in T<sup>3</sup> uptake values, metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, *J. Coll. Gen. Pract.* 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, *Brit. Med. J.* 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, *Brit. Med. J.* 2:651-657 (June 14) 1969. 4. Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives. An Epidemiologic Case-Control Study, *Amer. J. Epidemiol.* 90:365-380 (Nov) 1969.

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The Special Note, Contraindications, Warnings, Precautions and Adverse Reactions listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. *Starvation Ketosis:*

This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state.

**Do not give insulin without first checking blood and urine sugar.** 2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic

determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

**Adverse Reactions:** Principally

gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-D (6/72)

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# Centralized Pressure in Sphygmomanometry

CHARLES T. WEHBY, M.D.

FOR OBVIOUS REASONS, blood pressure studies are of paramount importance in the general appraisal of health status. Nevertheless, the technic has changed little since its discovery by Riva-Rocci in 1899, and the explanation of the auditory phenomena by Korotkoff in 1905.<sup>1</sup> It is the purpose of this article to present a new approach to determining sphygmomanometric status which, I believe, will facilitate the determination and realistically fit into modern methods of obtaining results, ie, a centralized, controlled source of air pressure which gives quicker and more accurate findings, without embarrassing patient acceptance or practicability.

## Materials and Methods

In order to reach an acceptable substitute for the time-honored manual air supply method, many technical problems were encountered and overcome. The pressure and volume of air needed were carefully computed to maintain a pressure and volume realistic for the intended study. The materials for conducting the air were carefully selected for their strength and ease of installation, together with their connecting elements. These included safety factors, built in, to prevent pressure from rising over 300 mm of mercury.

The rate of intake was suitably controlled from the central source by the use of a low-pressure regulator and flow valve (see "A" in Fig. 1), which not only maintained adequate pressure and volume at each cuff used, but also was calculated to have a reserve to maintain sufficient pressure when two or more cuffs were being used simultaneously.

Theoretically, two approaches to a centralized air supply were possible, ie, either a compressor with a tank to store air, or a cylinder with liquid gas under pressure. In view of the fact that the pressure and volume required were found to be

## The Author

• Dr. Wehby, Cincinnati, is in general practice, and is a member of the Medical Staff, Good Samaritan Hospital.

amazingly small, it was felt that, for practical purposes, a stored cylinder ("B" in Fig. 1) with an accessory reserve, served the purpose well and simplified installation and maintenance.

The type of gas used for pressure also posed a problem. After many experiments, it was decided that compressed air was the safest and most feasible, and no adverse effects to personnel or equipment have been encountered.

Of all the dilemmas encountered, the choice and design of the valve to introduce and release the pressure to the cuff was the most exacting and frustrating. It must be remembered that the present ball and valve used in sphygmomanometry is an admirably designed and time-tested instrument, and to duplicate its efficiency and remove its deficiencies (noise, labor, and unstable pressure increase to the cuff) required some ingenuity. After much research, a combination valve ("C" in Fig. 1) was decided upon. This unique instrument combines a push-button valve ("D" in Fig. 1) with an extremely small orifice to admit air to the cuff and a needle valve ("E") to hold and release air under controlled conditions, necessary in the technic of ascertaining blood pressure findings. The *raison d'être* for the extremely small orifice to admit air to the cuff was the importance of a slow, gradual increase in pressure, in order to monitor the systolic and diastolic pressures on *inflation*, thereby eliminating the need to add unnecessary pressure after the systolic sound disappears and also allowing the operator to release the air more quickly than hitherto, to the great relief of the patient. It must be emphasized that

the capability of noting the systolic and diastolic sounds on inflation represents a distinct advantage to both physician and patient, not noted by any previous investigator, and this potential arises from the unique supply and technic described above—the potential of millimetric increase and silence of operation hitherto impossible.

In the accompanying sketch (Fig. 2), it will be noted that the cylinders shown should be stored in an accessible area since the main valve should be closed when not in use, to prevent loss of air at the connecting elements. An accessory cylinder is not shown but is necessary in case there is depletion at unexpected intervals. This can be anticipated by using a gauge (see "A" in Fig. 2) to warn of impending depletion and to switch to the reserve and prevent unnecessary delay and inconvenience to the operator.

It is also important in installation, where many units are to be used, to increase the size of the tubing from the central sources—usually  $\frac{1}{2}$  inch to  $\frac{3}{4}$  inch and to connect smaller tubes ( $\frac{1}{4}$  inch) to each component. Unless this is calibrated, the regulator is not adjusted to a realistic level, the pressure and volume on simultaneous use will be inadequate.

It also might be of interest to note that self-adhering cuffs were found to be desirable in this operation. Their tendency to disengage, especially on obese individuals, was markedly lessened due, undoubtedly, to the smooth increase in pressure

in contradistinction to the jerky increase encountered with the ball-and-valve method. These cuffs not only saved time, but also acted as a "relief valve" in case pressures were inadvertently excessive and spontaneously released themselves. However, if the regulator is carefully adjusted, it can be predicted that the cuff pressure will not exceed a given level, unless some unforeseen problem arises, and then the spontaneous release of the cuff protects the patient. It is also important to apply the cuff snugly to the arm as this decreases the amount of air needed, accelerates the maneuver, and renders the cuff less liable to premature release.

Insofar as the efficiency of the system is concerned, it is of interest to note that approximately 17,000 blood pressure readings can be taken with a 15-lb tank of compressed air. It was determined, by inflating the cuff to 150 mm of mercury and displacing water with the trapped air in a measured container, that 300 cc of air was required. By using the formula  $PV = NRT$ , where:  $P$ =Pressure,  $V$ =Volume,  $N$ =Number of moles,  $R$ =Gas Constant (Kelvin), and  $T$ =Absolute temperature, the above figure was conservatively estimated.

### Comments

In modern day practice where many patients are examined in clinics, groups, etc, a faster, more accurate, and less laborious method of determining

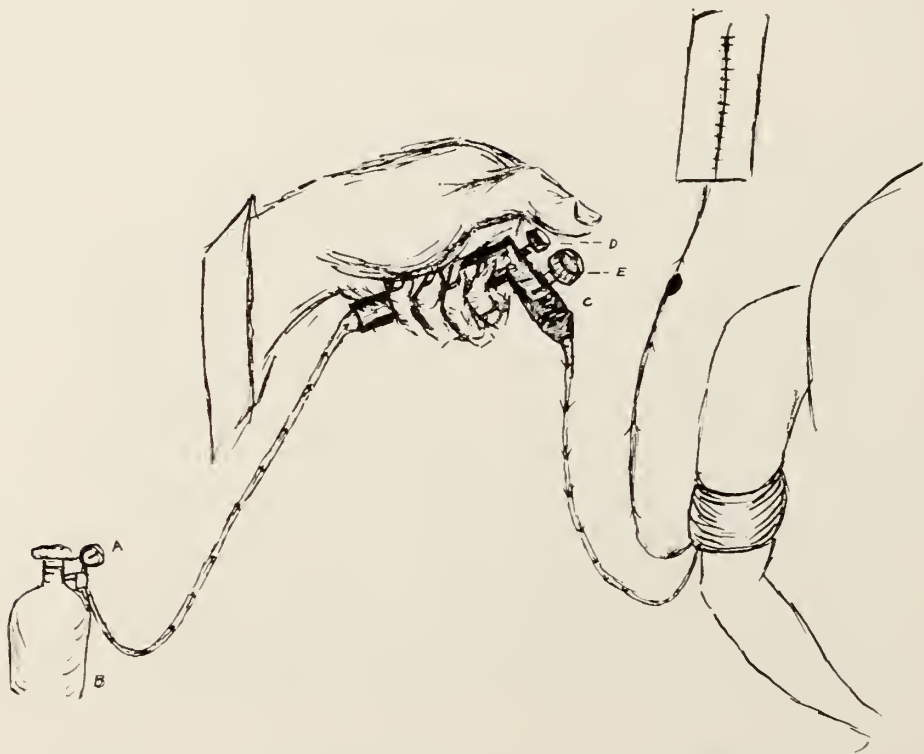


FIG. 1. Sketch showing low valve regulator (A), air cylinder (B), combination (C), pushbutton (D), and needle (E) valves.



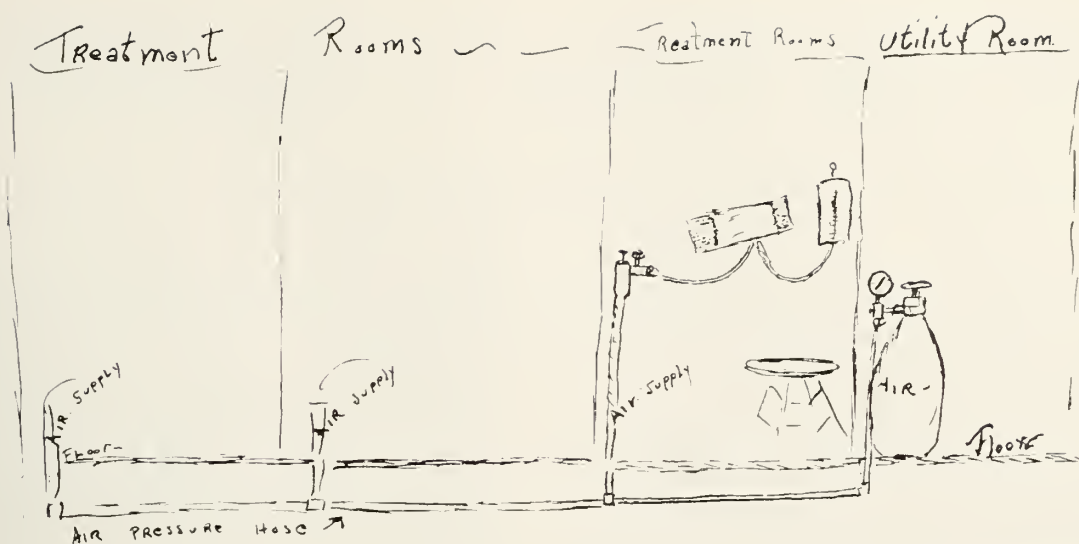


FIG. 2. Sketch of suggested storage arrangement.

blood pressure is desirable. The capability to monitor findings on inflation at millimetric increments is, I believe, a definite advance in technic. The acoustic phenomena described by Korotkoff in 1905 remain unchanged, but it was noted that the last sound heard on inflation and indicating the systolic pressure feathered for 3 to 5 mm before complete silence. This finding may indicate that due to the unique dynamics employed, a more accurate value for systolic status may be forthcoming.

### Summary

Sphygmomanometric determination is the sine qua non of any physical examination. An entirely new and realistic approach to cuff inflation in this important study is herewith presented. It is felt that it is feasible and allows the physician a simpler, faster, less painful and more accurate method of blood pressure evaluation. The capabili-

ty of monitoring the systolic and diastolic pressures while inflating the cuff, in my opinion, marks a definite advance in technic, since it greatly increases the speed, while at the same time it decreases the discomfort to the patient. Careful attention has been taken to insure patient safety and acceptance without penalizing the accuracy of the study. The unique choice of materials and design insures practical and carefree operation after the initial installation.

**Acknowledgment:** The valuable assistance of my sons, Charles T. Jr., James T., Richard C., and John H., is acknowledged.

### Reference

1. Gladstone SA: Concerning the mechanism of production of the Korotkoff sounds and their significance in blood pressure determinations. *Bull Johns Hopkins Hosp* 44:122-137, 1929.

**RULES FOR THE PROPER USE OF THE PAP SMEAR.** — (1) Screen females with genital symptoms, even children. (2) Screen pregnant women. (3) Take smear from endocervix, exocervix, and vaginal pool. (4) Class 1—Repeat smears yearly. (5) Class 1—With abnormal vaginal bleeding, ignore Pap smears, and study the patient to rule out cancer. Biopsy of any gross lesion should be done. (6) Class 2—Treat the cause until class 1 is demonstrated. (7) Classes 3, 4, 5—Study until cancer is ruled out. Evaluate vulva, vagina, cervix, uterus, tubes, and ovaries. — Robert R. Hughes, M.D., Memphis: *Southern Medical Journal*, 65:575-578, May, 1972.

# His Bundle Recordings And Arrhythmias

ALI A. EHSANI, M.D.\*

**R**ECORDING OF THE HIS BUNDLE electrogram has recently become established as a valuable diagnostic method in the critical differentiation between supraventricular and ventricular arrhythmias. Intracavitary His bundle electrograms were initially described in 1960 by Giraud and co-workers, but application of this technic in the clinical setting for arrhythmia diagnosis was introduced by Scherlag and associates in 1969. The technic is relatively simple because of the close anatomic relationship between the His bundle and the posterior leaflet of the tricuspid valve. Usually, a bipolar or tripolar catheter electrode is introduced into the femoral vein percutaneously and advanced into the right ventricle. Under fluoroscopic control, the catheter is then slowly pulled back until its tip is resting on the posterior leaflet of the tricuspid valve, a position from which His bundle potentials can be obtained readily. Alternatively, His bundle electrograms can be obtained from a cathetered tip adjacent to the noncoronary cusp of the aortic valve. However, this approach requires arterial puncture and hence is used only rarely.

Visualization of the His bundle potential requires special amplification and filtering equipment as well as adequate grounding of the entire system. In general, the filters are chosen to include frequencies between 40 and 500 Hz. The His bundle potential is manifest as a bi- or triphasic deflection occurring after atrial and before ventricular depolarization recognized by the P and QRS complexes on the simultaneously recorded electrocardiogram (ECG).

His bundle electrograms can be used to subdivide the P-R interval into PH and HV intervals. The PH interval (onset of the P wave on the ECG to the onset of the His bundle deflection) reflects the time required for intra-atrial and A-V nodal conduction time. The HV interval (onset of His bundle deflection to the onset of the QRS complex on the ECG) is a measure of conduction time in the distal His bundle and bundle branches as well as their ramifications. Normally, the PH interval varies between 80 and 140 msec and the HV interval varies between 35 and 55 msec. Pro-

longation of either interval signifies delay in conduction time in the corresponding regions of the conducting system.

Verification of the His bundle deflection is established by determining its timing with respect to atrial and ventricular depolarization. These should be consistent. In addition, pacing from the catheter tip from the which the His bundle deflection is recorded should produce QRS complexes which are indistinguishable from those seen with normal supraventricular beats.

## His Bundle Recordings and A-V Block

First-degree A-V block is electrocardiographically characterized by prolongation of the P-R interval exceeding 0.20 seconds. In general, in the absence of bundle branch block, prolongation of the P-R interval is due to PH interval prolongation reflecting A-V nodal conduction delay. On the other hand, first degree A-V block associated with bundle branch block is often due to prolongation of the HV interval alone or HV and PH. It should be noted that HV prolongation, perhaps auguring serious disease, may be present despite a normal P-R interval on the conventional ECG.

Second-degree A-V block is classified as Mobitz type I (or Wenckebach) and Mobitz type II block. Usually (although not always), Mobitz type I is associated with conduction delay in the A-V node. On the other hand, Mobitz type II block generally reflects bilateral bundle branch disease. His bundle recordings have helped to clarify these distinctions. Since bilateral bundle branch block, especially that associated with acute myocardial infarction, is more prone to produce sudden death, the distinction in an individual case is far from academic.

At least three varieties of complete A-V block are recognized: (1) block in the A-V node itself proximal to the His bundle in which His bundle deflections precede ventricular depolarizations and bear no relationship to atrial depolarizations; (2) block distal to the His bundle characterized by the presence of His bundle spikes which closely and consistently follow atrial depolarizations but bear no relationship to the QRS complexes; and (3) block in the His bundle itself characterized by split His bundle deflections with two distinct His bundle spikes,  $H_1$  and  $H_2$ , one of which is always associated with the atrial de-

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Provided by the American Heart Association, Inc. and made available to *The Journal* by the American Heart Association-Ohio Affiliate, Inc.

polarizations and the other with the ventricular depolarizations. However, there is no consistent relationship between  $H_1$  and  $H_2$ .

### Ectopic Beats

Analysis of His bundle recordings may furnish useful information regarding the origin of ectopic beats. Atrial premature beats are characterized by an early atrial depolarization, a prolonged PH interval, a normal HV interval, and normal or aberrant QRS morphology on the ECG. Ventricular premature beats on the other hand are not preceded by His bundle depolarizations. His bundle depolarizations may follow ventricular premature beats because of retrograde conduction. Occasionally, premature depolarizations arise from the His bundle itself (previously called nodal premature beats). However, such beats may not be manifest electrocardiographically because of antegrade block and retrograde block beyond the A-V junction. Rather, they may instead simulate unexplained first- or second-degree A-V block because of concealed retrograde conduction and protraction of the apparent refractory period of the A-V node. Although this phenomenon, known as "pseudo atrio-ventricular block," was first described many years ago, it has been documented only recently by Rosen and his associates in man.

### Tachyarrhythmias

Recording of His bundle electrograms has been helpful in analysis of complex tachyarrhythmias such as supraventricular tachycardia with aberrant conduction versus ventricular tachycardia. Again, QRS complexes in supraventricular tachycardia are preceded consistently by His bundle spikes while QRS complexes in ventricular tachycardia are not. His bundle recordings have shed light on the mechanism underlying some instances of supraventricular tachycardia. Recent

evidence suggests that many of these tachycardias are due to reentry of impulses through a pathway incorporating the upper A-V nodal and low atrial regions.

The PH interval is more susceptible than the HV interval to the effects of pharmacologic agents. Atropine, isoproterenol, and diphenylhydantoin decrease the PH interval but usually exert no effect on the HV interval. Propranolol prolongs the PH interval but has no influence on the HV interval. However, other drugs such as procaine amide may prolong both the PH and HV intervals.

### Stress of the Conduction System

Recognition of occult A-V nodal and sinus node dysfunction may be facilitated by stress of the conduction system by atrial pacing or acceleration of atrial rate with atropine while simultaneous His bundle recordings are obtained. The normal response to acceleration of atrial rate above 140 per minute is second-degree A-V block of the Mobitz type I variety. Production of block at rates lower than this indicates A-V nodal dysfunction. Sinus node dysfunction can be unmasked by stress as well. Sudden cessation of atrial pacing at a rate of 130 per minute normally leads to initiation of sinus node impulses within one second (the sinus node recovery time). This interval is significantly prolonged in patients with sinus node dysfunction (the "sick sinus syndrome").

### Summary

The technic of His bundle recording has been shown to be relatively simple and safe. It has already become an established means of obtaining clinically needed information useful in determining the nature of A-V block, the etiology of ectopic beats, the mechanisms underlying tachyarrhythmias, and the presence of occult sinus or A-V nodal disease in individual patients.

## Discussion of E.N.T. Case of the Month

*(continued from p. 114)*

The diagnosis is nasal septal hematoma, a condition caused by the extravasation of blood between the septal cartilage and its covering mucoperichondrium.

When a great deal of blood collects here, the septum may become markedly increased in diameter blocking the patient's airway. The red "masses" seen in this patient's nose are simply the septal mucosa which has been displaced laterally due to the underlying blood clot.

Treatment for this condition is prompt bilateral incision and drainage of the hematoma.

After the clot has been evacuated, the flaps of septal mucoperichondrium are repositioned against the septal cartilage and held in place by packing to prevent reformation of the hematoma.

If not treated promptly, septal hematomas may become infected creating a septal abscess, with the danger of additional complications. Chondritis of the septal cartilage then may occur resulting in collapse of the nasal bridge and formation of a "saddle nose" deformity. Cavernous sinus thrombosis is also a threat when infection occurs in this area.



# Professional Activities



## Proceedings of The Council

Meeting of December 15-17, 1972

A REGULAR MEETING of The Council of the Ohio State Medical Association was held Friday, Saturday and Sunday, December 15, 16 and 17, 1972, at the OSMA Headquarters' office, 17 S. High Street, Columbus.

Those present Friday evening were: All members of The Council (except Dr. James G. Tye, Dayton; Dr. George N. Bates, Toledo, and Dr. Robert G. Thomas, Elyria); Dr. Richard L. Meiling, Columbus, Chairman of the Ohio Delegation to the AMA; Dr. Wallace B. Dorain, Program Director, Ohio Regional Medical Program; Messrs. Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, David L. Rader, Mrs. Katherine E. Wisse, Mr. R. Gordon Moore, and Mrs. Gail Dodson.

Those present Saturday were: All members of The Council (except Dr. Bates); Dr. John H. Budd, Cleveland, a member of the AMA Board of Trustees; Dr. John W. Cashman, Columbus, Ohio Director of Health; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Mr. James S. Imboden, Columbus, Assistant Director, AMA Department of Field Service; Mr. Bernard D. King, Columbus, Student AMA Representative; Dr. Perry R. Ayres, Athens, Editor of *The Ohio State Medical Journal*; Mr. Robert B. Canary, Mr. Frederick J. Zuber, and Mr. Theodore T. Fry, Columbus, representing the Ohio Department of Public Welfare; Dr. Richard L. Fulton, Columbus, a Past President of the Ohio State Medical Association; and all members of the OSMA staff, with the exception of Mr. Edgar.

Those present Sunday were: All members of The Council (except Dr. Bates), Dr. Budd, Mr. Pohlman, Mr. Imboden, Mr. King, all members of the OSMA staff (except Mr. Edgar and Mrs. Dodson).

### Minutes Approved

Minutes of the meeting of September 29, 30 and October 1, 1972, were approved.

### Councilor Reports

The Councilors reported on activities in their respective districts.

### Membership

Mrs. Wisse presented membership statistics for December 14, 1972, showing a net gain in membership of 53 members over the same date last year.

AMA membership showed a loss of 114 members over the same period.

### Auditing and Appropriations

The Council then adjourned and reconvened in Executive Session for consideration of the Budget for 1973.

The minutes of the Auditing and Appropriations Committee, including the following recommendations, were approved as submitted:

The proposed computerized membership system was discussed. It was the consensus of the

Committee that the membership department further analyze the system to be implemented and its utilization, and present this to the Membership and Planning Committee for its recommendation to The Council.

The Committee recommends to The Council that the usual custom of Christmas gifts for the employees be followed in 1972.

The Committee recommends to The Council that the following new appointments be made effective January 1, 1973:

Herbert E. Gillen, Director of Government Relations

Jerry J. Campbell, Director of Specialty Society Services

Robert D. Clinger, Director, Department of Health Education

David L. Rader, Assistant Director, Department of State Legislation

Katherine E. Wisse, Comptroller

The following budget was adopted by official action:

Budget for 1973

|  |              |
|--|--------------|
| The Ohio State Medical Journal (10,200 members @ \$4.50) .....         | \$ 45,900.00 |
| Executive Salaries .....   | 135,250.00   |
| Staff Expense .....  | 20,000.00    |
| Staff Associate, Secretarial and clerical salaries .....               | 93,456.00    |
| President:   |              |
| 1972-1973 Expense .....  | \$3,000.00   |
| Honorarium ..  | 5,000.00     |
| 1973-1974 Expense .....  | 3,000.00     |
| President-Elect:   |              |
| 1972-1973 Expense .....  | \$1,800.00   |
| Honorarium ..  | 2,000.00     |
| 1973-1974 Expense .....  | 1,800.00     |
| Secretary-Treasurer:   |              |
| Honorarium ..  | \$2,000.00   |
| Council Expense .....  | 18,500.00    |
| AMA Delegate-Alternate Expense (per diem \$35; Ground travel \$20) ... | 22,000.00    |
| Committees:  |              |
| Ad Hoc on Health Care Delivery Systems .....                           | 1,500.00     |
| Auditing and Appropriations .....                                      | 4,000.00     |
| Cancer .....   | 550.00       |
| Emergency and Disaster Medical Care .....                              | 750.00       |
| Education (Commission on Education) .....                              | 2,000.00     |
| Environmental and Public Health ....                                   | 1,000.00     |
| Eye Care .....   | 500.00       |
| Government Medical Care Programs ..                                    | 1,500.00     |
| Hospital Relations .....   | 1,000.00     |
| Insurance .....  | 600.00       |
| Judicial and Professional Relations ...                                | 500.00       |
| Laboratory Medicine .....  | 400.00       |
| Liaison Committee to Nationwide Insurance .....                        | 200.00       |
| Maternal Health .....  | 2,400.00     |
| Medicine and Religion .....  | 200.00       |
| Membership and Planning .....  | 2,500.00     |
| Mental Health .....  | 2,000.00     |
| Nursing .....  | 150.00       |
| OSMA-OSBA Liaison .....  | 200.00       |
| Private Practice .....   | 750.00       |
| Professional Standards Review Organization .....                       | 5,000.00     |
| Placement Service .....  | 750.00       |

Committees—contd.

|   |              |
|---|--------------|
| Public Relations .....                  | 400.00       |
| Rehabilitation .....                    | 100.00       |
| Rural Health .....                      | 1,500.00     |
| School Health .....                     | 5,000.00     |
| Scientific Work .....                   | 600.00       |
| Workmen's Compensation .....            | 250.00       |
| Annual Meeting .....                    | 65,000.00    |
| Car Lease .....                         | 7,200.00     |
| Councilor District Conferences .....    | 3,600.00     |
| Data Processing .....                   | 25,000.00    |
| Emergency Fund .....                    | 5,000.00     |
| Equipment Rental .....                  | 14,000.00    |
| Family Practice Scholarships .....      | 4,000.00     |
| Insurance and Bonding .....             | 14,000.00    |
| Legal Expense .....                     | 20,000.00    |
| Library .....                           | 600.00       |
| OSMAgram .....                          | 7,500.00     |
| Postage .....                           | 12,000.00    |
| Professional Relations Activities ..... | 5,000.00     |
| Public Relations Department:            |              |
| Information Materials .....             | 1,500.00     |
| Miscellaneous Activities .....          | 5,000.00     |
| Rent .....                              | 31,142.76    |
| Stationery, Printing and Supplies ..... | 12,500.00    |
| Taxes: Payroll .....                    | 10,000.00    |
| Telephone and Telegraph .....           | 9,500.00     |
| Depreciation .....                      | 2,000.00     |
| Furniture and Equipment .....           | 4,000.00     |
| TOTAL BUDGETED FOR 1973 ...             | \$648,548.76 |

The Executive Session was adjourned and The Council reconvened in regular session.

Dr. Dorain Introduced

Wallace B. Dorain, M.D., Program Director for the Ohio Regional Medical Program was introduced and spoke briefly to The Council.

American Medical Association

The Council voted to commend Ohio's AMA Delegation and to extend its thanks and appreciation to the Hamilton, Butler, Stark and Montgomery County Medical Societies for the successful hosting of the Clinical Session of the American Medical Association. The Council also voted to encourage return of the AMA Clinical Session to Cincinnati at a future date.

Dr. Meiling reported on the sessions of the AMA House of Delegates in Cincinnati and brought to the attention of The Council the work of Ohio's Delegates to the AMA and especially that of Dr. Frederick P. Osgood, of Toledo, with regard to Report "H" of the Council on Medical Education. This report is entitled "Functions and Structure of a Medical School—For Accreditation Guidelines" and was referred by the AMA Delegates back to the Council on Medical Education for revision.

The Council adopted a position paper on this matter and voted to officially request of the Coun-

cil on Medical Education that the Ohio State Medical Association be given a hearing and selected Dr. P. John Robeck as its spokesman.

### OSMA Annual Meeting

Mrs. Dodson reported on plans for the OSMA Annual Meeting, May 6-9. Her report was **accepted** for information.

Mr. Campbell reported on exhibit sales.

### County Society Officers Conference

The Council voted to authorize the officers to select a date for the 1973 County Society Officers' Conference; to change the name of the Conference; to select, if possible, a place out of Columbus; determine the program, and provide the officers with blanket authority to select decision-makers in medicine to attend the meeting.

### Constitution and Bylaws

The revised Constitution and Bylaws of the Ashland County Medical Society were **approved**, subject to correction of several minor clerical errors.

The revised Constitution and Bylaws of the Wayne County Medical Society were **approved**, subject to correction of a section of the Bylaws which would have provided active membership in more than one county medical society.

Consideration of the Hancock County Medical Society Constitution and Bylaws revision was **deferred**, because of language conflicting with the OSMA Bylaws on matters of appeal.

### Medical Advances Institute and Professional Standards Review

Dr. Henry reported to The Council on developments concerning Medical Advances Institute and Professional Standards Review.

The Council expressed the opinion that Dr. Henry's name should be submitted as a member of the proposed "Eleven Man National Advisory Committee on Professional Standards Review Organizations."

Mr. Page announced the successful passage of S. B. 496, Aronoff, which will provide protection to physicians on Professional Standards Review Organization committees of medical societies and Medical Advances Institute. The bill will become effective March 31, 1973.

The Council authorized Mr. Page to accept an appointment as Chairman of the American Association of Medical Society Executives' Ad Hoc Committee to Plan PSRO Workshops.

### Ohio Medical Indemnity

Dr. Robeck and Mr. Page reported for the OMI Liaison Committee. It was announced that Dr. Wells had been elected to the Board of Directors of OMI and, therefore, has relinquished his place on the OMI Liaison Committee. Dr. Schultz appointed Dr. Lieber to succeed Dr. Wells on the OMI Liaison Committee and the appointment was ratified by The Council.

### Woman's Auxiliary

The Council discussed the legislative program conducted by the Woman's Auxiliary to the American Medical Association. The Council requested that the Ohio State Medical Association Woman's Auxiliary consult with the officers or The Council of the Ohio State Medical Association, with regard to materials issued by the Woman's Auxiliary to the AMA, before such programs are implemented.

### Committee Reports

#### Joint Advisory Committee on Special Education

Minutes of the October 11 and November 15 meetings were presented by Mr. Clinger. The minutes of the October 11 meeting were **approved**. Item "B" which accompanied the November 15 minutes was referred back to the committee for clarification. The remainder of the minutes of that date were **accepted**.

#### Joint Committee on School Bus Driver Examinations

Minutes of the October 12 meeting of the Joint Committee on School Bus Drivers were presented by Mr. Clinger. The Council, **approved, in principle**, a proposed letter from the chairman of the committee to the Chief of the Pupil Transportation Section of the Ohio Department of Education, with a copy to Superintendent Martin Essex, and **accepted** the minutes for information.

#### Ohio Cancer Coordinating Committee, Inc.

Minutes of the October 18 meeting of the Ohio Cancer Coordinating Committee, Inc., were presented by Mr. Clinger and were **accepted** for information.

#### Judicial and Professional Relations Committee

Minutes of the October 25 and November 19 meetings of the Judicial and Professional Relations Committee, were presented by Mr. Page, and were **accepted** for information.



### OSMA-OSBA Liaison Committee

Minutes of the November 1 and December 13 meetings of the OSMA-OSBA Liaison Committee, were presented by Dr. Clarke and were received for information.

### Committee on Rural Health

Minutes of the November 5 meeting of the Committee on Rural Health were presented by Mr. Clinger and were accepted for information.

### Commission on Medical Education

Minutes of the November 8 meeting of the Commission on Medical Education were presented by Mr. Campbell, in the absence of Mr. Edgar.

In answer to the Commission's request for direction of The Council on the subject of physician's assistants, The Council requested that consideration not be given to licensure, but that consideration be directed toward certification, with the requirement that those certified serve under the direction of physicians.

The Council then discussed the organization and function of the Committee for Expanded Medical Education in Ohio and its mission of studying and recommending methods to implement the study of medical education in Ohio, conducted for the Ohio Board of Regents by Philip Lee, M.D., Chancellor of the University of California School of Medicine. It was the direction of The Council that all available avenues be utilized to achieve OSMA input into the plans which are being developed under the aegis of the Ohio Board of Regents.

The remainder of the minutes were accepted by The Council.

### Committee on Medicine and Religion

The minutes of the November 16 meeting of the Committee on Medicine and Religion were presented by Mr. Campbell and were accepted.

### Committee on Membership and Planning

The minutes of the December 6 meeting of the Committee on Membership and Planning were presented by Dr. Wells and Mr. Gillen.

A proposed resolution to change the Constitution and Bylaws of the Ohio State Medical Association, in order to establish a new membership category, "Members in Training" was approved by The Council for submission to the House of Delegates in 1973.

A recommendation of the committee with regard to increasing membership of psychiatrists

was referred to the Committee on Mental Health for implementation.

The Council directed Dr. Wells, chairman of the committee, to explore the reinstituting of lectures for medical students.

A report from Mr. Campbell, Director of Specialty Society Services, to the Membership and Planning Committee, was included in the minutes and was received for information.

A proposed computerized membership system for the Ohio State Medical Association, submitted by Mrs. Wisse, OSMA Comptroller, and William Wisse, Computer Consultant, was accepted as a basic working document.

The minutes, as a whole, were approved.

### Committee on Mental Health

Minutes of the December 10 meeting of the Committee on Mental Health were presented by Mr. Clinger.

In connection with a report on prescription controls, The Council directed that the subject be referred for discussion by the OSMA Committee on Pharmacy with the related committee of the Ohio State Pharmaceutical Association. The Committee on Mental Health, however, was authorized to continue its study and discussions of this matter.

A recommendation that the Board of Pharmacy prepare an article on the current drug laws for the *Ohio State Medical Journal* was referred to Mr. Moore for implementation.

The remainder of the minutes were accepted as presented.

### Ad Hoc Committee for the Study of Health Care Delivery Systems

The minutes of the December 13 meeting of the Ad Hoc Committee for the Study of Health Care Delivery Systems were presented by Mr. Gillen. The report was approved in principle and the committee was instructed to proceed with its work.

### Committee on Workmen's Compensation

The minutes of the December 13 meeting of the Committee on Workmen's Compensation were presented by Mr. Campbell, and were accepted.

### Committee on Private Practice

The minutes of the December 13 meeting of the Committee on Private Practice were presented by Dr. Lieber.

With regard to the section on certification of need, The Council approved the recommendation that the committee survey the medical associations in the nine states which have defeated such legislation, as well as the 16 states which have

enacted it, for the purpose of obtaining specific information as to whether the state medical association favored or opposed the legislation; and if it was defeated, why it was defeated; and if it was enacted, how it is working.

The report of the committee was accepted as presented.

### Committee on Eye Care

Minutes of the October 22 meeting of the Committee on Eye Care were presented by Mr. Rader.

With regard to optician registration, The Council expressed its opinion that in view of the OSMA policy, calling for a moratorium on further licensing, proposed legislation for the registration of opticians be **disapproved**.

The minutes were **approved** as amended.

### Committee on Emergency and Disaster Medical Care

Minutes of the meeting of the Committee on Emergency and Disaster Medical Care, December 2, were presented by Mr. Rader.

The Council amended the recommendation of the committee to read as follows:

"That the Ohio State Medical Association and the Ohio Hospital Association work together to discuss a hospital licensure bill, which would include categorization of emergency facilities."

The minutes were **accepted**, as amended.

### Dr. Cashman Addresses Council

Dr. Cashman, Ohio Director of Health, then addressed The Council.

He discussed the Task Force on Hospital Licensure and Certification of Need. He announced a meeting of the full Task Force for late in January. He stated that the medical profession should draft that part of the bill relating to quality.

Dr. Cashman stated that there is an urgency for the states to work in the fields of comprehensive planning, access to health care, and provision of state funds for medically needy.

Dr. Cashman discussed the chronic renal disease revisions of H.R. 1, pointing out that provisions had been made for care of chronic renal patients under Medicare.

The Council requested that Dr. Cashman meet with it for a "think session" on various mutual problems in the health field, at a time in the near future.

### Mr. Canary

Mr. Canary, Acting Director, Ohio Department of Public Welfare, then addressed The Council. He admitted that physicians with substantial

numbers of welfare patients have been badly hurt because of slow payment by the Department. He presented figures indicating that in the fiscal year ending July 1, 1972, payments of \$11,294,000 had been made to physicians, with an additional \$892,000 as co-insurance and deductibles under Medicare. At the conclusion of Mr. Canary's presentation, The Council discussed various details with Mr. Canary, Mr. Zuber and Mr. Fry.

### Ohio State Medical Journal

Dr. Ayres addressed The Council, with regard to developments in the state medical journal field. As a member of the Board of Directors of the State Medical Journal Advertising Bureau, representing 34 State Medical Journals, plus the *Chicago Medical Society Bulletin* and *Massachusetts Medicine*, Dr. Ayres expressed his concern that the pharmaceutical industry is not using these journals adequately in advertising programs, but instead many of the members of the industry were using heavy advertising budgets in so-called controlled circulation magazines, medical publications which have no official ties with medical organizations.

Council authorized the Publication Committee of *The Journal* to develop a communication program between physicians and the pharmaceutical manufacturers to make them aware of this situation. In addition, Mr. Page was authorized to discuss with the Big Ten state medical societies the possibility of a conference with the Pharmaceutical Manufacturers Association and its members.

### Lab Tests

A communication from Dr. R. G. Thomas, Secretary-Treasurer of the Ohio Society of Pathologists, with regard to proposed FDA regulations which might stipulate what laboratory tests a physician could order for the diagnosis of certain categories of diseases, was **received** for study and information.

### Bacteria on Aircraft

A report on Ohio State Medical Association and Ohio Society of Pathologists action concerning regulations by the United States Department of Transportation, which would prohibit transport of bacterial cultures on passenger carrying aircraft, was presented to the Council for information.

### Proposed Food and Drug Regulation

The Council studied information concerning proposed Food and Drug regulations governing blood and blood banks. A number of the regulations were of concern to The Council, including

one which would designate blood as a drug; whereas, in Ohio distribution of blood is by statute designated as a service, not a sale. OSMA directed that Ohio Congressmen and the American Medical Association be contacted on this matter.

#### Resolution on Department of Public Welfare

A resolution from the Academy of Medicine of Columbus and Franklin County, regarding the Ohio Department of Public Welfare new program for the administration of Title XIX, was received by The Council and the District Councilor was asked to advise the Academy of the activities of The Council in attempting to deal with this situation.

#### Resolutions on Provider Agreements

Resolutions from the Delaware County Med-

ical Society and the Clermont County Medical Society on provider agreements were received by The Council.

#### Sympathy Expressed

The Council expressed its sympathy to Charles W. Edgar and his family, with regard to the death of his mother, Mrs. Rose King Edgar, Columbus, Ohio, on December 14, 1972.

#### Future Meetings of the Council

Future meetings of the Council were tentatively set for January 27-28 and March 17-18, 1973.

ATTEST: Hart F. Page  
*Executive Director*

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### ON THE OMPAC FRONT

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## OMPAC Board of Directors Reorganizes for '73

At the recent annual meeting of the Board of Directors of the Ohio Medical Political Action Committee, the following Board members were re-elected for three-year terms:

Frank H. Mayfield, M.D., Cincinnati; Lawrence C. Meredith, M.D., Oberlin; James C. McLarnan, M.D., Mt. Vernon, and Ray W. Gifford, M.D., Cleveland.

Officers were reelected as follows: William J. Lewis, M.D., Dayton, chairman; H. William Porterfield, M.D., Columbus, vice-chairman; Carl A. Lincke, M.D., Carrollton, secretary-treasurer.

Dr. Lincke tendered his resignation as a member of the Board and as secretary-treasurer. He stated that he had been a Board member from the inception of OMPAC in 1946 and felt that he should be relieved from Board membership. His resignation was accepted with regret and Dr. Lincke was thanked for his long and faithful service on the Board and as its efficient secretary-treasurer.

Paul A. Jones, M.D., Zanesville, a Board member was elected secretary-treasurer to succeed Dr. Lincke. Wesley J. Pignolet, M.D., Willoughby, Lake County, was elected to serve the unexpired term of Dr. Lincke as a Board member, such term expiring in 1973.

The Board also accepted with regret and thanks for fine past service, the resignation of Charles L. Blumstein, M.D., Lima, who stated

that he may move from Ohio in the near future. It was decided that the Board would act to fill this vacancy at an early meeting.

Other Board members are: Robert E. Tschantz, M.D., Canton; A. Burton Payne, M.D., Ironton, and Mrs. M. W. Sloan, Dayton.

Possible activities to increase OMPAC membership and extend the educational activities of OMPAC were discussed, such as: Sending personalized letters to those who have or have not contributed during the year; issuance of a regular Newsletter or bulletins at intervals; solicitation by direct mail; establishment of closer contact between the Board members and officials of the State Association and the county medical societies; urging greater interest on the part of county societies and individual physicians in the selection of candidates for local and county public offices, before and after, the primary elections; selection of "key men" in the counties to boost OMPAC membership, and similar projects.

\* \* \*

Have you made your 1973 OMPAC contribution of \$25 through your County Medical Society Secretary-Treasurer? If not, it's not too late. In fact it's never too late to contribute to OMPAC. Now is the time for OMPAC to start building up its funds for the crucial 1974 General Election.

—Ohio Medical Political Action Committee



# A Few Program Highlights

## The 1973 OSMA Annual Meeting . . . .

### Colon and Rectal Diseases

TUESDAY, MAY 8, 1973

The following program is planned by the OSMA Section on Colon and Rectal Surgery and the Ohio Valley Proctologic Society, at the Veterans Memorial Building.

#### The Program

- |  |  |
|--|--|
| Presiding: Burchard E. Winne, M.D., Toledo,<br>Program Chairman  | 2:50 p.m. Questions and Answers<br>Moderator — Burchard E. Winne,<br>M.D., Toledo  |
| 2:00 p.m. <b>“What Are Fiberoptics”</b> —Mr. Phillip<br>Klein, Chief Engineer, Owens-<br>Corning Fiberglass Corp., Toledo.   | 3:00 p.m. Coffee Break   |
| 2:15 p.m. <b>“The Impact of Flexible Fiberoptic<br/>Colonoscopy Upon the Manage-<br/>ment of Colonic Disease”</b> — Gerald<br>Marks, M.D., Assistant Professor<br>Clinical Surgery, Jefferson Medical<br>College, Philadelphia, Pa., Consul-<br>tant in Colon and Rectal Surgery<br>to the U. S. Army Hospital, Valley<br>Forge, Pa., and to the Veterans<br>Administration Hospitals in Coates-<br>ville, Pa. and San Juan, Puerto<br>Rico. | Presiding: Ralph Samson, M.D., Columbus  |
| 2:30 p.m. <b>“The Psychologic Aspect of the Nurse<br/>in Fiberoptic Procedures”</b> — Sandy<br>Price, R.N., Dept. of Gastroenter-<br>ology, Mercy Hospital, Toledo.  | 3:10 p.m. <b>“The Use of Synthetic Low Residue<br/>Diets in the Management of In-<br/>flammatory Bowel Disease”</b> —Fran-<br>cis S. Kleckner, M.D., Allentown,<br>Pennsylvania.           |
| 2:40 p.m. <b>“Medical Aspect of Fiberoptics”</b> —<br>Francis S. Kleckner, M.D., Direc-<br>tor of Gastroenterology, Laboratory<br>and Endoscopy Unit, Allentown<br>Hospital, Allentown, Pa.  | 3:20 p.m. <b>“The Fatal Face of Fistula in Ano<br/>with Abscess: An Analysis of Eleven<br/>Deaths”</b> — Gerald Marks, M.D.,<br>Philadelphia, Pennsylvania.                                |
|  | 3:35 p.m. <b>“Office Management of Perianal Ab-<br/>scess”</b> — J. H. Wittoesch, M.D.,<br>Dayton.   |
|  | 3:50 p.m. Panel Discussion: Perianal Abscess<br>Moderator — Ralph Samson, M.D.,<br>Columbus<br>Panel Participants: Gerald Marks,<br>M.D., J. H. Wittoesch, M.D. and<br>Gerson Carmel, M.D. |

# American Heart Association Ohio Affiliate

Annual Scientific Session  
in Cooperation with the  
Ohio State Medical Association Annual Meeting

Wednesday, May 9, 1973 9:00 - 10:30 a.m.

Veterans Memorial Building  
Columbus, Ohio

## Participants

J. Lester Kobacker, M.D., Toledo, President,  
American Heart Association — Ohio Affiliate

William R. Schultz, M.D., Wooster, President,  
Ohio State Medical Association

William C. Sheldon, M.D., Cleveland, Member,  
Department of Cardiovascular Disease and  
the Cardiac Laboratory, Cleveland Clinic  
Foundation

Welcome — Dr. Schultz

Introduction of Lecture — Dr. Kobacker

The Rudolph Allen Gerlinger Memorial Lecture  
of the American Heart Association — North-  
western Ohio Chapter

**“Evolution of Myocardial Revascularization: From  
Thrombo-endarterectomy to Bypass Grafts”**  
—Dr. Sheldon

## Ophthalmology

WEDNESDAY, MAY 9, 1973

The following program is sponsored by the OSMA Section on Ophthalmology and the Ohio Ophthalmological Society. The scientific portion will be held in the Veterans Memorial Building.

### The Program

Presiding: William J. Crawford, M.D., Middle-  
town, Chairman, Section on Oph-  
thalmology

3:00 p.m. **“Complications of Strabismus Surg-  
ery”** — Ronald L. Price, M.D., Di-  
rector of Pediatric Ophthalmology  
at the Cleveland Clinic.

3:30 p.m. **“Practical Aspects of Fluorescein An-  
giography”** — Frederick H. Davi-  
dorf, M.D., Assistant Professor, De-

partment of Ophthalmology, Ohio  
State University, Columbus.

4:00 p.m. **“Therapy of Corneal Diseases”** —  
Richard H. Keates, M.D., Professor  
of Ophthalmology and Director of  
Corneal Service at Ohio State Uni-  
versity, Columbus.

4:30 p.m. Business meeting of the Section on  
Ophthalmology.  
(See Next Page)

## “A Day in the Emergency Department”

WEDNESDAY, MAY 9, 1973

Veterans Memorial Building

Moderator: R. C. Waltz, M.D., Cleveland

- |            |  |           |  |
|------------|--|-----------|--|
| 9:30 a.m.  | “The Emergency Department — Today's Needs — Tomorrow's Demands” — Robert C. Waltz, M.D., Chairman, Ohio Committee on Trauma, A.C.S.  | 1:30 p.m. | “Plastic Surgery for the G.P.” — Ronald B. Berggren, M.D., Dept. Plastic Surgery, Ohio State University.   |
| 9:45 a.m.  | “The Unconscious Patient with Obvious Trauma” — William E. Hunt, M.D., Professor, Neurosurgery, Ohio State University.   | 1:50 p.m. | “Pitfalls in ‘Simple’ Fractures” — Robert S. Heidt, M.D., Department of Orthopaedic Surgery, University of Cincinnati.                                 |
| 10:00 a.m. | “The Unconscious Patient Without Obvious Trauma” — Arnold H. Greenhouse, M.D., Cleveland Clinic.   | 2:10 p.m. | “Returning the Sport Injury to the ‘FRAY’ ” — George W. Ballou, M.D., Cincinnati. Member, American College of Surgeons.                                |
| 10:15 a.m. | “The Battered Child” — Robert J. Izant, Jr., M.D., Director, Pediatric Surgery Division, Babies & Children's Hospital; and Professor, Pediatric Surgery, Case Western Reserve University, Cleveland. | 2:30 p.m. | “Returning the Industrial Injury to the ‘Grind’ ” — Joseph Solomeyer, M.D., Medical Director, General Motors, Hudson.                                  |
| 10:35 a.m. | Coffee Break   | 2:50 p.m. | Coffee Break   |
| 11:00 a.m. | What Would You Do?<br>“Chest Pain and the Normal EKG” — Sylvan L. Weinberg, M.D., Dayton. Chairman, Cardiovascular Center and Director, Coronary Care Unit, Good Samaritan Hospital.                 | 3:05 p.m. | “Evaluating the Acute Abdomen” — Marion C. Anderson, M.D., President, Medical College of Ohio at Toledo; and formerly Chairman, Department of Surgery. |
| 11:15 a.m. | “Dangerous Arrhythmias in the Emergency Department”—Thomas E. Driscoll, M.D., University Hospitals, Cleveland.   | 3:20 p.m. | “Early Recognition and Management of Shock” — Robert Zollinger, M.D., Case Western Reserve University, Cleveland.                                      |
| 11:30 a.m. | “Taking the Emergency Department to the Patient” — James V. Warren, M.D., Chairman, Dept. of Medicine, Ohio State University.  | 3:40 p.m. | “Should I Use an Antibiotic?” — Emanuel Wolinsky, M.D., Metropolitan General Hospital, Cleveland.  |
| 12:00 noon | Lunch and Inspection of MICU (Mobile Intensive Care Unit) and Team<br>Moderator: Robert S. Heidt, M.D., Cincinnati   | 4:00 p.m. | “Tetanus Prophylaxis—Still a Problem” — Wesley Furste, M.D., Columbus. Past Chairman, Ohio Committee on Trauma, A.C.S.                                 |
|            |  | 4:15 p.m. | “Minor Problems, ‘Goofs’ and Other Dilemmas—A Kodachrome Clinic” — Robert C. Waltz, M.D., Cleveland, Chairman, Ohio Committee on Trauma.               |



# Program for Medical Assistants in Connection with 1973 OSMA Annual Meeting

Tuesday, May 8, 1973

“THINGS YOU ALWAYS WANTED TO  
KNOW—BUT WERE AFRAID TO ASK”

|           |   |           |   |
|-----------|---|-----------|---|
| 2:00 p.m. | Welcome — Jack Schreiber, M.D.,<br>Canfield   | 3:10 p.m. | “To Unite, or Not to Unite, That Is<br>the Question?” <ul style="list-style-type: none"><li>• HMO’s — What Are They?</li><li>• Doctor’s Union — Any Place for<br/>Them in Ohio?</li><li>• Solo or Group Practice?</li></ul> Speaker: William J. Lewis, M.D., Dayton   |
| 2:05 p.m. | “Where Do Doctors Stand?” <ul style="list-style-type: none"><li>• Future of Health Care</li><li>• OSMA Stand on Basic Issues</li><li>• Principles of Private Practice</li></ul> Speaker: William R. Schultz, M.D. Wooster,<br>President, Ohio State Medical As-<br>sociation  | 3:25 p.m. | Question and Answer Period  |
| 2:20 p.m. | Question and Answer Period  | 3:30 p.m. | “Looking at Yourself in the Mirror”<br>(Public Relations) <ul style="list-style-type: none"><li>• The Telephone — First Contact<br/>with the Patient</li><li>• In the Office — the Personal<br/>Touch</li></ul> Round Table:<br>Physician — John Budd, M.D.,<br>Cleveland<br>Medical Assistant — Judy Lowe,<br>Columbus<br>County Executive — Robert Lang,<br>Executive Secretary, Cleveland<br>Academy of Medicine |
| 2:30 p.m. | “What ‘Bugs’ You the Most?”<br>(General Office Problems) <ul style="list-style-type: none"><li>• Insurance Forms</li><li>• Welfare</li><li>• Billing Procedures</li><li>• The “No Show” Patient</li><li>• The “Walk In” Patient</li><li>• Scheduling</li></ul> Round Table:<br>General Practitioner — Jerry L.<br>Hammon, M.D., West Milton<br>Medical Assistant — Anita Perkins,<br>Columbus<br>Professional Management of Cleve-<br>land — Frank Caulkins, General<br>Manager | 4:00 p.m. | Question and Answer Period  |
| 3:00 p.m. | Question and Answer Period  | 4:10 p.m. | “What it Takes to be a Really Good<br>Medical Assistant”<br>(Attitudes)<br>Speaker: Jack Schreiber, M.D., Canfield  |
|           |   | 4:30 p.m. | Adjourn<br>Short philosophical Inspirational Time   |

# MAKE YOUR HOTEL RESERVATIONS For The 1973 OSMA Annual Meeting COLUMBUS, OHIO

MAY 6-9

Leading Downtown Columbus  
Hotels at Prevailing Rates

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50 North Third Street  
(OSMA Headquarters)

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| Singles | \$19.00 - \$31.00 |
| Twins   | \$26.00 - \$38.00 |

## NEIL HOUSE MOTOR HOTEL

41 South High Street  
(OSMA Overflow Hotel)

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| Singles | \$14.00 - \$23.00 |
| Doubles | \$18.00 - \$28.00 |
| Twins   | \$19.00 - \$26.00 |

## SOUTHERN HOTEL

South High and East Main Streets

|         |                   |
|---------|-------------------|
| Singles | \$12.00 - \$13.00 |
| Doubles | \$15.00 - \$16.00 |
| Twins   | \$15.50 - \$20.00 |

## CHRISTOPHER INN

300 East Broad Street  
(Woman's Auxiliary Headquarters)

|         |      |
|---------|------|
| Singles | \$15 |
| Doubles | \$20 |
| Twins   | \$23 |

## HOLIDAY INN - DOWNTOWN

175 East Town Street

|         |      |
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| Twins   | \$20 |

All rates subject to change. If you plan to share a room, please indicate name of roommate.



## HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

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(Name of Hotel)  
\_\_\_\_\_  
(Address) Columbus, Ohio

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 6-9, 1973 (or for period indicated).

|                   |                            |
|-------------------|----------------------------|
| _____ Single Room | _____ Twin Room            |
| _____ Double Room | Other Accommodations _____ |
| Price Range _____ | Guaranteed _____           |

Arrival: May \_\_\_\_\_ at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.  
Departure: May \_\_\_\_\_ at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

PLEASE VERIFY MY RESERVATION

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# Kids' Stuff

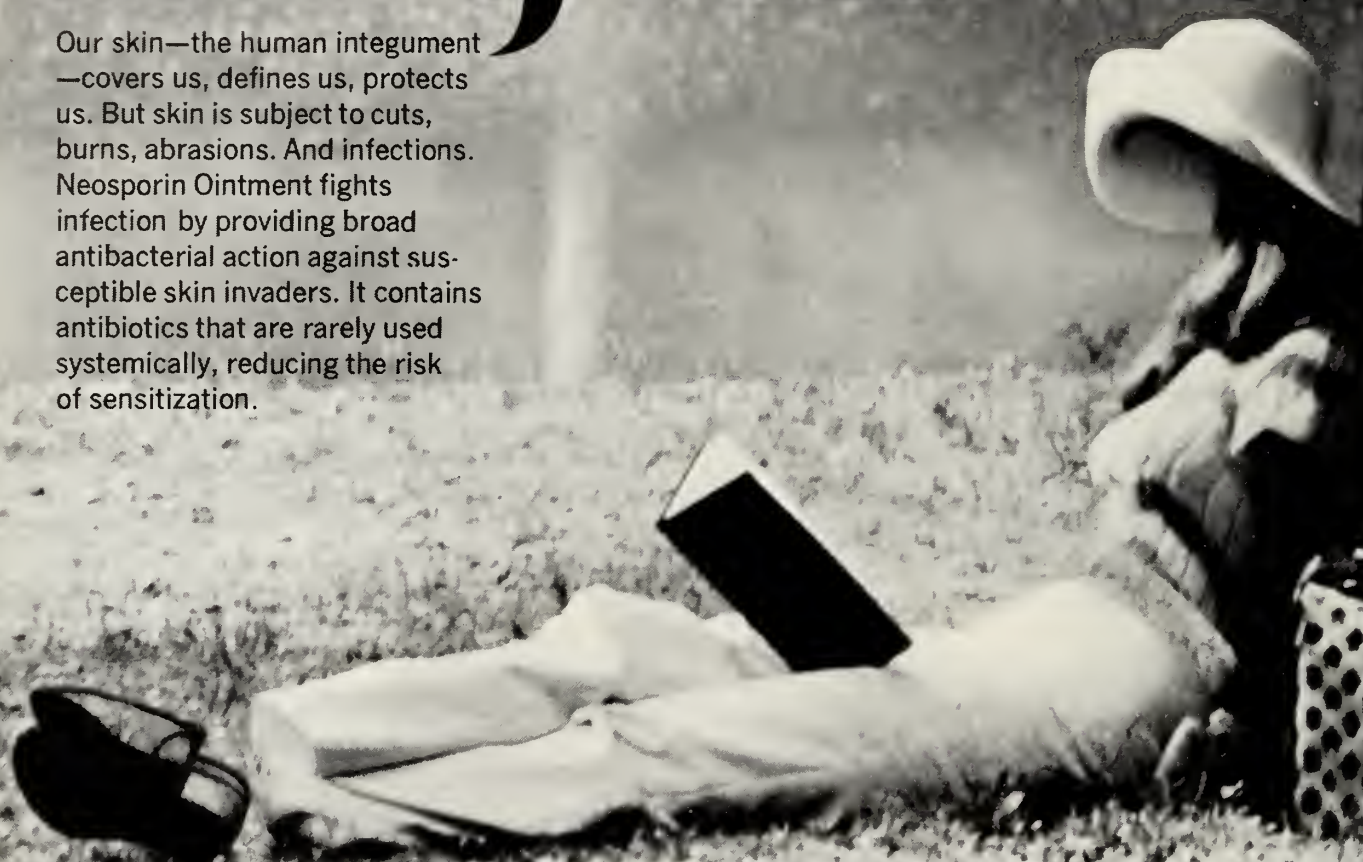
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**INDICATIONS:** *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in:

- infected burns, skin grafts, surgical incisions, otitis externa
- primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia)
- secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis)
- traumatic lesions, inflamed or suppurating as a result of bacterial infection.

*Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

**CONTRAINDICATIONS:** Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

**PRECAUTION:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

## NEOSPORIN<sup>®</sup> Ointment

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Each gram contains: Aerosporin<sup>®</sup> brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and ¼ oz. (approx.) foil packets



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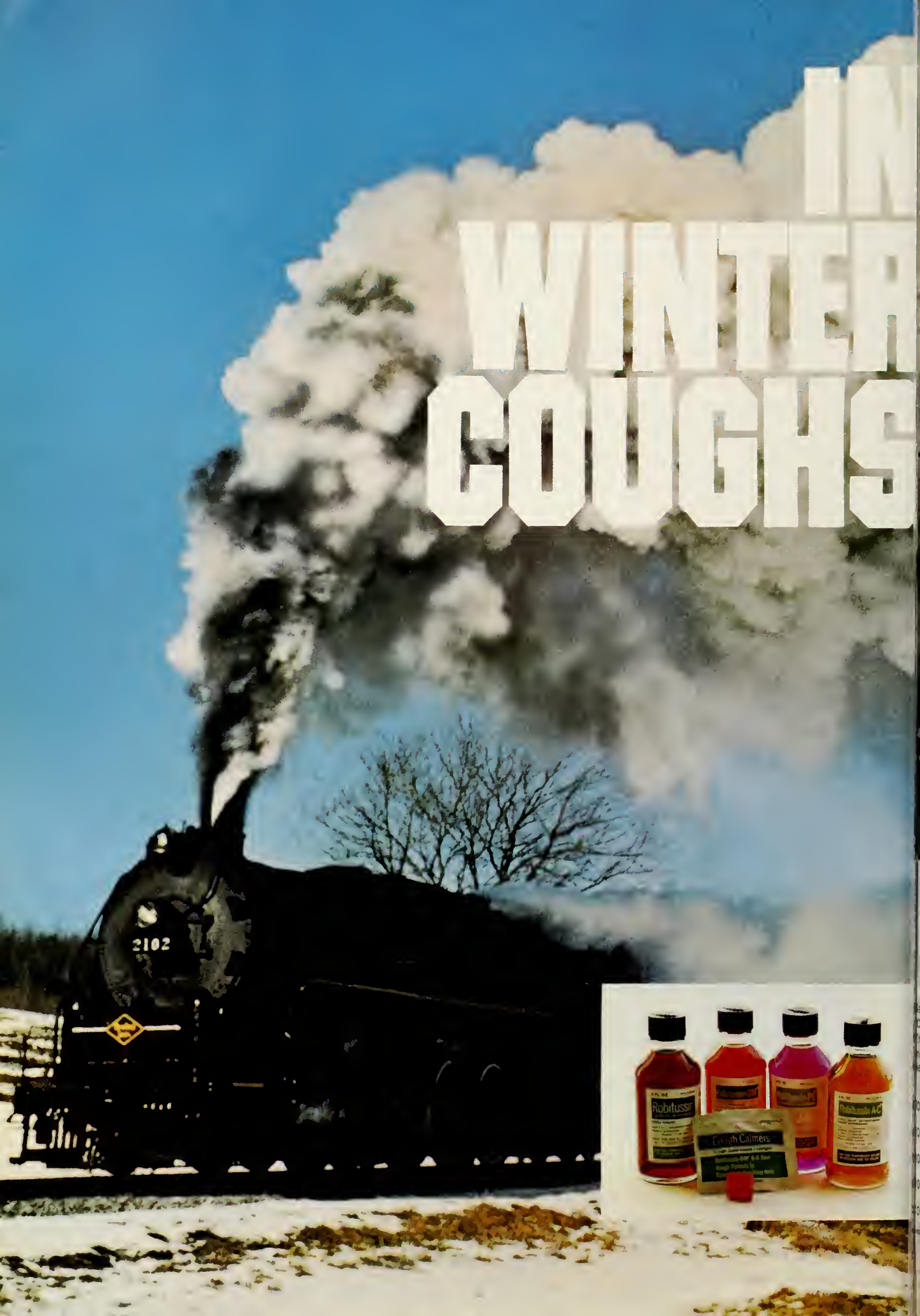
Available on oral prescription or without prescription under limited circumstances as modified by applicable state law.

Each 30 cc. contains: Kaolin, 6.0 g.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; opine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Powdered opium, USP, 24.0 mg. (Warning: may be habit forming); Sodium benzoate (preservative), 0 mg.; Alcohol, 5%. A.H. Robins Company, Richmond, Virginia 23220

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Glyceryl guaiacolate ..... 100 mg.  
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Non-narcotic for 6-8 hr. cough control

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Relieves cough, clears sinuses and nasal passages—  
keeps them "drip-dry" but not bone dry

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That Treats Your Patient's  
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| ROBITUSSIN A-C <sup>®</sup> | ●                         | ●                    | ●             |                            |                              |              |
| ROBITUSSIN-DM <sup>®</sup>  | ●                         | ●                    |               | ●                          |                              | ●            |
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## 1973 Annual Meeting, Ohio State Medical Association

**DO YOU HAVE AN EXHIBIT** or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1973 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be Monday through Wednesday, May 7, 8 and 9.

Mail applications to the attention of Jerry J. Campbell, Exhibit Manager, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

### APPLICATION FOR SPACE SCIENTIFIC EXHIBITS

## 1973 Annual Meeting, Ohio State Medical Association

**Veterans Memorial Building, Columbus, May 7, 8 and 9**

1. Title of Exhibit: \_\_\_\_\_
2. Name(s) of Exhibitor(s): \_\_\_\_\_  
Institution (If desired): \_\_\_\_\_  
City \_\_\_\_\_
3. Do you have a built-in exhibit? \_\_\_\_\_
4. Booth Requirements: Back wall \_\_\_\_\_ All side walls are 6' deep  
(indicate footage)
5. Description of Exhibit: (Attach 200 word description to this blank)

**Deadline For Filing Applications, February 15, 1973**

# Obituaries

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**Charles Phillips Adkins, M.D.**, Coldwater; Emory University School of Medicine, 1930; aged 67; died November 29; member of OSMA, AMA, and American Society of Abdominal Surgeons; practicing physician and surgeon in the Mercer County community for some 38 years.

**William Vaughn Banning, M.D.**, Newark; Ohio State University College of Medicine, 1931; aged 66; died December 5; member of OSMA, AMA, and the Radiological Society of North America; Fellow of the American College of Radiology; diplomate, American Board of Radiology; practitioner in Newark since 1956, specializing in radiology; previously practiced in Shreve and during World War II served in the Army Medical Corps.

**Julien Emil Benjamin, M.D.**, Cincinnati, University of Cincinnati College of Medicine, 1912; aged 83; died November 29; member of OSMA, AMA, and Central Society for Clinical Research; Fellow, American College of Physicians; diplomate, American Board of Internal Medicine; practitioner in Cincinnati for more than 50 years; active in Public Health Federation, Family Service, Family Welfare Association; veteran of World War II.

**Irving Black, M.D.**, Gahanna; Eclectic Medical College, Cincinnati, 1919; aged 78; died December 19; member of OSMA and AMA; former medical examiner for the Pennsylvania Railroad; retired in recent years.

**Merle Franklin Bossart, M.D.**, Akron; Jefferson Medical College of Philadelphia, 1919; aged 77; died December 6; member of OSMA, AMA, and American Academy of Family Physicians; retired in 1970 after practicing for more than 50 years, most of that time in Akron.

**Austin John Brogan, M.D.**, Dayton; Harvard Medical School, 1931; aged 67; died December 8; member of OSMA, AMA, and Radiological Society of North America; Fellow, American College of Radiology; diplomate, American Board of Radiology; practicing radiologist of long standing in Dayton; former president of Ohio State Radiological Society; veteran of World War II.

**Stanley Elwood Dorst, M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1923; aged 75; died December 6; member of

OSMA, Central Society of Clinical Research and American Society for Clinical Investigation; diplomate, American Board of Internal Medicine; Cincinnati internist and dean of the University of Cincinnati College of Medicine from 1940 to 1962; president of the Association of American Medical Colleges, 1952-1953, and cited with the AAMC's Flexner Award for distinguished service to medical education; member of the AAMC-AMA commission to study British medicine in the 1930's. Among survivors is a son, Dr. John P. Dorst, of Baltimore, Md.

**Adam David Echert, M.D.**, Millersport; Eclectic Medical College, Cincinnati, 1918; aged 79; died December 3; member of OSMA and AMA; practitioner for many years in Columbus, in the fields of general practice and EENT, and in recent years in the Buckeye Lake area where he made his home; veteran of World War I.

**Ernest W. Ekermeier, M.D.**, Tallahassee, Fla.; University of Cincinnati College of Medicine, 1931; aged 66; died December 2; resident physician at the Ohio Soldiers and Sailors Orphan Home, Xenia, before World War II; moved to Florida after military service during the war.

**Dorothy Waldron Jordan, M.D.**, Columbus; Ohio State University College of Medicine, 1960; aged 46; died December 17; recent member of OSMA and AMA; member of American Society of Anesthesiologists; resident physician at the Columbus State Hospital.

**Alex Eugene Krill, M.D.**, Chicago, Illinois; Ohio State University College of Medicine, 1954; aged 44; died December 8 in the crash of a commercial airliner in Chicago; member of a number of professional organizations and specialist in ophthalmology.

**William Howard Kuby, M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1941; aged 56; died November 28; member of OSMA and AMA; practitioner in Cincinnati for a number of years, specializing in internal medicine; veteran of World War II.

**Davis Lillard, M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1919; aged 78; died December 26; member of OSMA; practitioner in Cincinnati for more than 50 years.

*(Continued on Next Page)*



Norman Benedict Muhme, M.D., Toledo; University of Michigan Medical School, 1921; aged 76; died December 15; member of OSMA and AMA; lifelong resident of Toledo and practitioner there for more than 50 years, in the fields of general practice and general surgery.

Walter Stanley Novak, M.D., Port Huron, Mich.; Western Reserve University School of Medicine, 1936; moved to Michigan shortly after taking his medical school work and internship in Cleveland.

Louis Stephen Persell, M.D., Pasadena, Calif.; St. Louis University School of Medicine, 1935; aged 68; died December 4; former member of OSMA; practiced in Hudson and Alliance before moving to California about 1948.

Harry Clay Powelson, M.D., Zanesville; Ohio State University College of Medicine, 1924; aged 73; died December 25; member of OSMA and AMA; Fellow, American College of Surgeons; physician and surgeon in Zanesville since 1930; practiced in association with his brother, Dr. Myron H. Powelson who survives.

James Joseph Sunseri, M.D., Cleveland; University of Pittsburgh School of Medicine, 1924; aged 77; died December 7; member of OSMA and AMA; general practitioner in Cleveland for some 46 years.

Louis Joseph Tornambe, M.D., Cleveland; University of Catania, Italy, 1954; aged 47; died December 24 while on a vacation trip in Florida; member of OSMA, AMA, and American Society of Abdominal Surgeons; practitioner in Cleveland for a number of years, specializing in obstetrics and gynecology.

## Columbus Physician Gives Lecture at Wisconsin College

Dr. Robert M. Zollinger, chairman of the Department of Surgery at Ohio State, was the first Ellison Visiting Professor of Surgery at the Medical College of Wisconsin. The memorial lectureship was established in the name of Dr. Edwin H. Ellison who died in 1970, after more than ten years as head of surgery at the Wisconsin college.

While Dr. Ellison was at Ohio State, he and Dr. Zollinger proposed the diagnostic triad which now appears in standard reference books as the Zollinger-Ellison syndrome. Dr. Zollinger's topic for the lecture was "The Legacy of William Beaumont."

Dr. Calvin G. Jackson, Kenton, was guest speaker for the Ada Kiwanis Club's Pearl Harbor Day memorial meeting. He related his talk to memories of World War II including his survival of the Bataan Death March and more than three years as prisoner of the Japanese.

"The Wonderful World of Dr. Neiswander" was the title given to a special program staged in Doylestown on November 5. Hundreds of people of the community gathered in the Chippewa High School to honor Dr. Byron E. Neiswander, a practitioner in the Doylestown area for 38 years. An illustrated feature article relating Dr. Neiswander's contributions to the community appeared in the *Daily Record*, Wooster newspaper.



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HERBERT A. SIHLER, Jr.  
President

# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

THE VITAL IMPORTANCE of safety is never very far from our awareness because, in the truest sense, it can be a matter of life or death. Yet a curious kind of carelessness too often relegates that awareness to an attitude of the ostrich sticking its head in the sand. Not too long ago, I came across a most unusual kind of prayer written by the Rev. Robert A. Grunow, of Concordia Seminary in St. Louis, Missouri. Its "theme" is that of safety and I feel its message is definitely well worth passing on:

"Safety is of Thee, O Lord, but I have not always been a wise steward of this great gift. Forgive me and help me appreciate my personal responsibility in our national safety movement. Grant me grace to realize that safety is not primarily dependent upon laws and legislation, upon rules and regulations, upon programs and promotion, but upon me.

"Where there is disinterest in safety, let me bring zeal for saving lives. Where there is discourtesy and carelessness, let me bring concern. Where there is a dearth of education and information, let me bring understanding. Where there is delay in adopting defensive driving programs or engineering improvements, let me bring responsible leadership.

"Where there is disrespect for law enforcement and our judicial system, let me bring sup-

port. Where there is destruction, disfigurement and death, let me bring a sense of moral responsibility. Where there is disregard for human life, let me bring spiritual motivation.

"I am only one, O Lord, but I am one. Use me to bring Thy safety to my community, my city and my country. In the name of and for the sake of our Lord, Amen."

Certainly this little prayer speaks for itself. How about its speaking for you?

## Woman In The News

Mrs. Edward Bauman, Trumbull County, former president of the Woman's Auxiliary to the Ohio State Medical Association, has recently been elected president of the American Lutheran Church Women for a three-year term. Margaret has served on the Board of Social Service of the American Lutheran Church and is still serving in that capacity.

She is president of the Warren City School Board, historian of our state auxiliary and a member of the American Association of University Women. Dr. and Mrs. Bauman live in Warren where Dr. Bauman is an orthopaedic surgeon. They are the parents of five children and have four grandchildren. The charming Margaret is a graduate of Case Western Reserve, with a Bachelor of Arts and Masters of Nursing degrees. We

---

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are happy to salute another outstanding and dedicated doctor's wife!

### Around the State

Whether volunteers can help curb child abuse is being explored by the Cuyahoga County auxiliary. To learn about the problem, the group recently invited Dr. James H. Ryan, pediatrician and author, to speak at its luncheon meeting at the Cleveland Yachting Club. Dr. Ryan practices in Kankakee County, Illinois where he is also coroner. He has studied the battered child syndrome extensively and is the author of "Suffer the Little Ones," a novel dealing with "child murder."

According to Dr. Ryan, between 5,000 and 6,000 children are murdered every year by their parents or by other adults. Another 50,000 to 60,000 children suffer some form of abuse, he said. "The worst part," he added, "is that this is very likely just the tip of the iceberg . . . there is a vast number of abuses frequently hidden as 'accidents.'"

Dr. Ryan spoke of those who perpetrate child abuse as not necessarily "monsters" but they are pathetic, sick people desperately in need of treatment.

This luncheon meeting of the Cuyahoga auxiliary was the first program in the group's year-long study of the child abuse problem. Mrs. Robert H. Perchan, auxiliary president, says she became interested in the battered child syndrome when her daughter investigated it as a social worker at University Hospitals. Dr. Ryan was invited to speak by Mrs. Frank Meany, program chairman, after she read about his work in that field.

To continue its study, the auxiliary scheduled a second luncheon in January with local police, medical and social work experts as speakers (de-

tails on the second luncheon will be given in a later column). Members of the Lake and Ashtabula auxiliaries were invited to the luncheon at which Dr. Ryan spoke.

### Guest Day Tea

Kenneth Levin, a doctoral candidate in East Asian History at the University of Wisconsin, presented a program on Red China at the November meeting of the Lucas County auxiliary held at the Academy Building. Mr. Levin was a member of the first group of American China scholars in over 23 years to visit the Peoples' Republic of China.

This was a five-week trip of most of the major Chinese cities, rural communes, schools, hospitals and historical sights. Mr. Levin has spoken with Prince Norodon Sihanock of Cambodia, officials of North Korea and Premier Chou En-lai. In his talk before the auxiliary, he revealed his impressions of the nature of Chinese society today and discussed the prospects for the future of China.

In keeping with the Guest Day program, the tea table of refreshments featured foods from the Orient. Cynthia Apostolakis and Tessie Boucouras, cochairmen of the refreshments, had a remarkable committee of seven, to help in the preparation of the egg rolls and other Cantonese delicacies that were served. This committee included Frances Petas, Bess Philip, Kay Van der Veer, Patsy Kropp, Kay Parker, Virginia Binkley and Sue Eriksen. Barbara Klein was program chairman of the day.

The *Toledo Blade* featured a large photograph of three auxiliary members "at work"—sorting and boxing equipment and pharmaceuticals for the group's annual World Medical Relief



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drive. Pictured were Mrs. Dorrence C. Talbut, Mrs. John Orwig and Mrs. Carl Dreyer.

The Lucas auxiliary sponsored the first Coffee Concert on January 10 in the home of Mrs. Robert Youngen. All the hostesses for the first of these traditional community Coffee Concerts were doctors' wives and two of the performers were auxiliary members Mrs. Robert L. Hauman and Mrs. Russell V. Howard.

Here and There

Montgomery County auxiliary's November meeting featured a talk on "The Problems of the 70's" by Dr. Jansen at the Bergamo Center . . . . The "Sugar Plum Shoppe" netted approximately eight hundred dollars for the group's Philanthropic fund . . . . "Coming up" is the auxiliary's Twenty-Fifth Anniversary Dance to be held on February 7th. Two tickets to the Kentucky Derby will be raffled off on that festive occasion.

"Northeastward"

I am indebted to Mrs. Robert Gilliland, treasurer of the Mahoning County auxiliary, for the attractive year-book which was sent to me. I particularly liked the idea of placing the year-book in a good-sized loose-leaf notebook that makes it possible for each member to jot down important bits of auxiliary information or reminders or outstanding comments and so on.

Mahoning is always a busy group. The September meeting was a "Membership Brunch" at the home of Mrs. Patrick Cestone. Cohostess was Mrs. Rashid Abdu. There is no more important function, I feel, than one honoring and introducing new members.

The group's October meeting was an "AMA-ERF Benefit Fashion Show" and "Mini-Bazaar" as well as a Guest Day luncheon. It was held in the Blue Room of Cherry's Top O' The Mall with the fashions from Hartzell's. Chairman for the day was Mrs. Joseph Sofranec and cochairman was Mrs. James Sofranec. The November luncheon meeting stressed "Political Action" and was a joint meeting with the Trumbull County auxiliary at Avalon Inn. Mrs. Malachi W. Sloan, national regional North Central legislative chairman, was the speaker. Mrs. S. F. Petraglia was chairman of the day.


District Meeting

The Tuscarawas County auxiliary served as hostess for the District 7 meeting which was held in November at the Atwood Lodge. Auxiliary members from seven cities and towns attended. Tables were decorated with brown baskets holding colored mums. Mrs. Dan Wherley of New Philadelphia made the special dessert that was served.

State Board members attending included Mrs. Louis Loria, president; Mrs. Karl Ulicny, president-elect; Mrs. Paul Hahn, treasurer; Mrs. Christopher Colombi, program development chairman; and Mrs. F. A. Sunseri, district 7 director. Mrs. Loria addressed the group, as did Mrs. Colombi. Mrs. Colombi stressed five important objectives of any meeting: to learn something, to solve problems, to share experiences, to think and participate and to influence the group.

"Romance" of Shoes

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Philip Walker and he operates a shoe store in Lancaster. His family began in the shoe store business back in the 1800's and Mr. Walker has made the "romance" of shoes into a fascinating study. He visited the Scioto County auxiliary in November as guest speaker at its meeting at the home of Mrs. John Walker. And he brought with him an amazing collection of shoes. None was more amazing than the giant-sized one (and I do mean "giant-sized"! ) of leather over sawdust that used to serve as the store's "trademark." (It was placed in front of the door in lieu of a sign to designate the "bootmaker shop").

Mr. Walker's talk on shoes started with the caveman who tied skin around his feet as a functional necessity. It was Egypt which developed shoe technology, said Mr. Walker. He went on to explain that it was the Greeks who started the emphasis on beauty and design and were responsible for the first "elevator" shoes. The Romans came up with special kinds of shoes for waging war! Mr. Walker's presentation was vivid, factual and tied in with many events of historical significance.

A Thomas Beard of the Massachusetts colony was the first known shoemaker in this country. It was amazing to learn that it took centuries for man to make shoes that would be designated specifically for the right foot and the left foot!

The business meeting which followed Mr. Walker's talk was conducted by Mrs. David Livingston, Scioto president. To enable underprivileged children in the community to attend the Ohio University Portsmouth Branch Children's Theatre Production, the group voted a \$25 contribution. Mrs. Charles Wendelken conducted a moving memorial service for the late Mrs. R. P. Elder.

## At Random

I have been rereading "The Right Side of the Caduceus," the story of the first Fifty Years of the National Auxiliary. From the epilogue, I have picked certain comments I particularly like:

"The doctor's wife of 1922 did not face the same problems as her counterpart in 1972. That the world today is quite different sociologically, medically, economically, scientifically and technologically, is undisputed. Any thoughts of television, organ transplants or of "planting" the American flag on the moon would have been met with astonishment and disbelief, but are established facts today. And just as television, organ transplants and moon walks were unthought of, so, too, would be the necessity for the educational programs on teenage venereal disease control, immunization (with all the advances in this field since 1922), Block Mother Plan, drug abuse, alcohol or sex education produced within the auxiliary and presented throughout the nation. The organization has kept in step with the times, faced these problems and offered solutions . . .

"Yet despite all the sweeping changes that have occurred in this half century, the basic principles and policies of the auxiliary have remained the same: to assist the American Medical Association in its program for the advancement of medicine and public health; to coordinate and advise concerning the activities of constituent auxiliaries; to cultivate friendly relations and promote mutual understanding among physicians' families . . ."

These are some wonderfully warm thoughts for the cold month of February!

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# New AMA Magazine Will Deal with Social and Economic Issues

The American Medical Association has announced plans for a new magazine directed to American physicians.

The first issue of the new monthly, *Prism*, is scheduled for April, 1973.

The circulation will be free to all members of the AMA and will include all office-based physicians engaged in patient care and all residents in their final year of training. Total circulation will be more than 200,000.

Addressing itself to the socioeconomic questions of health care and medicine, *Prism* is in re-

sponse to the demands of physicians and its publication has been encouraged by medical specialty groups. Physicians have expressed the need for authoritative articles dealing with the social, ethical, economic, and philosophical implications of medicine.

## Deadline for Submission of Resolutions to OSMA Office is March 7

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1973 Annual Meeting should be guided by Chapter 4, Section 8 of the OSMA Bylaws entitled "Resolutions."

"Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates."

## Provisions in OSMA Bylaws Pertaining to Nomination of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 6-9.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal*, unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 7.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect."

"Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon the filing of such candidate's name, the Executive Director shall prepare and transmit this information to each member of the House of Delegates. No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal."



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**References:** 1. Montesano, P. and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12 69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5 67, 1964. 3. Tietz, A. S. Methyltestosterone thyroid in treating impotence. Gen Prac 25 5, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. J. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19 936, 1959. 5. Farris, E. J., and Cotton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79 863, 1958. 6. Odel, A., and Farrar, G. E. United States Dispensatory (ed 25). Lippincott, Philadelphia, 1955, p 1432. 7. Wershub, L. P. Sexual impotence in the Male. Thomas, Springfield, Ill., 1959, pp 79-99.

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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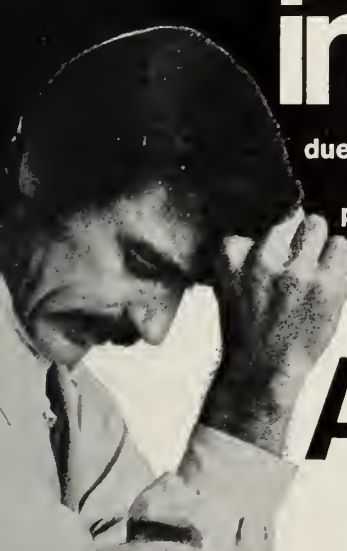
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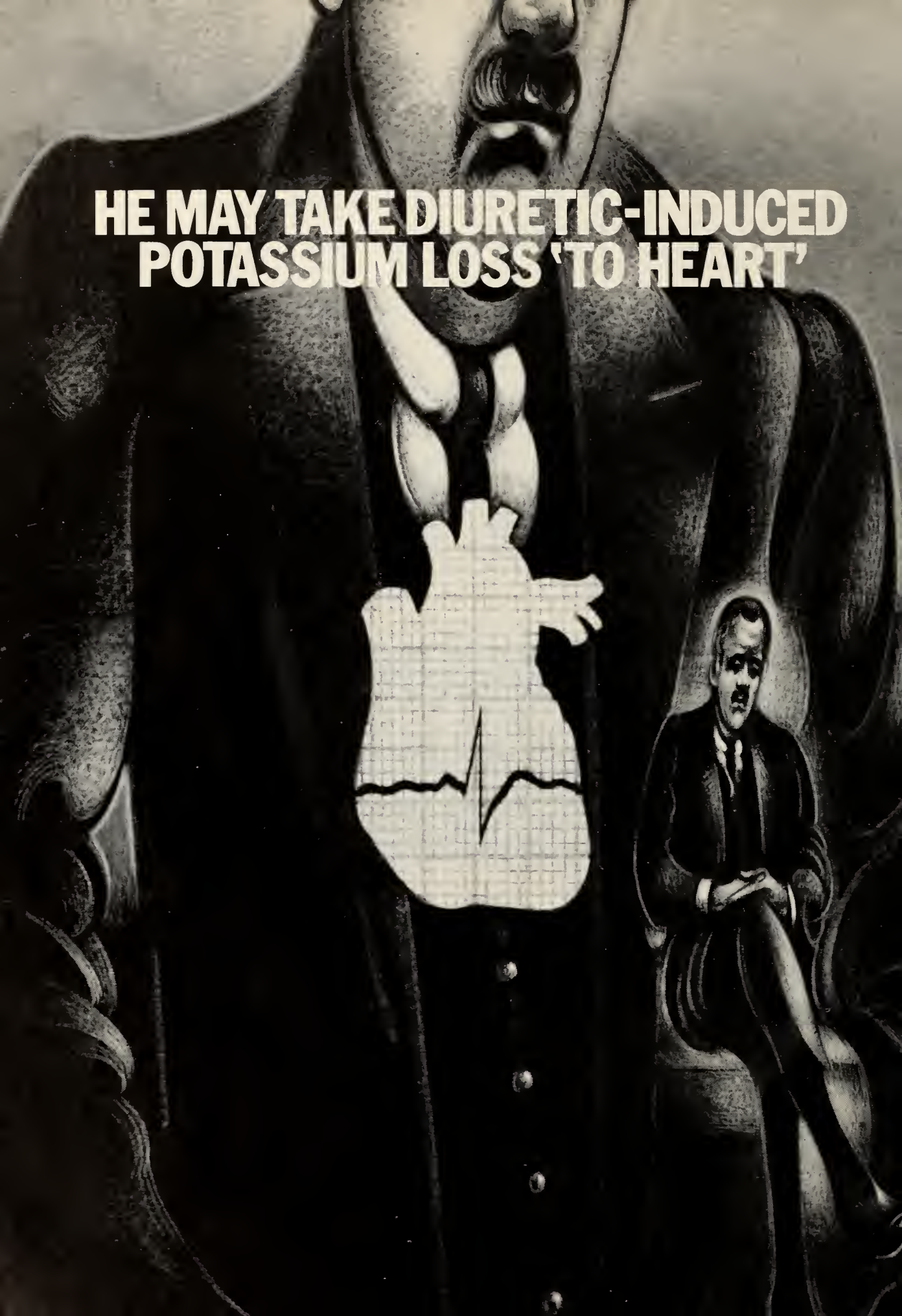
Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Monteleone, P., and Evannellato, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tittel, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Melman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid androgen interrelations and the biochemical effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and l-thyroxine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensary (ed. 28). Lippincott, Philadelphia, 1955. p. 1432. 7. Warshub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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LABORATORIES

# The Role of the Community Hospital In Internal Medical Residency Programs

By ROBERT E. TSCHANTZ, M.D.

Chairman, AMA Committee on Private Practice

FIRST, on behalf of Dr. Bill Schultz, President of the Ohio State Medical Association, I would like to extend greetings from that organization; and, secondly, on behalf of the American Medical Association's Committee on Private Practice, I would like to officially thank Bill Ruhe and George Mixer, from the Council on Medical Education, and each of the members of this distinguished panel for coming to Ohio and discussing the role of the community hospital in internal medical residency program. I hope this pilot conference will prove so successful that it may be reproduced in other areas of our community. It is my belief that finding resolutions to problems discussed here could have a most important impact on the future of American medicine. If the views that I express seem abrasive, you must be-

lieve they are only meant to serve as a stimulus for better communication.

The problems of the community hospital are just about the same as the problems that face the medical community as a whole . . . namely, we have a maldistribution in the numbers of physicians and too few of the type of physicians that can serve as primary physicians. In very small communities primary physicians might well be family practitioners; in larger communities the primary physician could be a family practitioner, general internist, general pediatrician, and even a general surgeon. Time does not permit a full discussion of the reasons for this maldistribution or scarcity of primary physicians, but certainly the availability of research funds played a dominant role in the '60's. The scarcity of these funds in the '70's may also have something to do with the renewed interest by the university community in patient care and in health delivery systems. The end results for many community hospitals has been the availability of cardiac pediatricians, but no general pediatricians; the availability of cardiologists capable of catheterizing the heart, but no general internists; or the availability of cardiac sur-

---

Dr. Tschantz is a practicing physician in Canton. He is a Past President of the OSMA, and an Ohio Delegate to the AMA. This article is the text of an address before the Ohio Workshop on Residencies in Internal Medicine, sponsored by the American Medical Association and held in Cleveland, January 22, 1973.

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geons, but no general surgeons. It is my belief that keeping community hospitals in the main stream of post graduate education could go a long way towards solving this most perplexing problem.

For many years those concerned with setting standards for resident programs single mindedly have been interested in one thing—"good education." This, of course, is a goal worthy of any educator's time; however, like so many things in modern day living, decisions reached to achieve one goal, no matter how worthy, often must be reexamined if the offshoots of these decisions are harmful to medicine as a whole. I believe that such a thing could be happening in postgraduate training and it is on this point that I would like to address the few minutes allotted in this opening session.

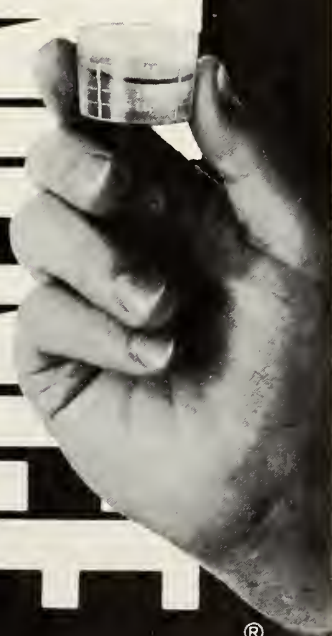
It seems to be a widely held view that all postgraduate education in the future will be under the supervision of medical schools. Time does not allow a full discussion of this, but certainly during the past ten years in Ohio the distribution of residencies in internal medicine seems to bear this out. In 1962 Ohio's nonaffiliated or loosely affiliated community hospitals made up 83 percent of all hospitals in Ohio offering 50 percent of the residencies in internal medicine. In 1972 the non-affiliated or loosely affiliated community hospitals made up 70 percent of the hospitals offering 30 percent of the programs in internal medicine. I offer these figures only to show the dramatic trend towards the university hospitals domination of programs in internal medicine. Not only has the number of residencies dropped in nonaffiliated community hospitals, but the number of foreign physicians in their programs has increased. I sincerely believe this trend is at least partially responsible for the shortage of practicing physicians in many areas; it is partially responsible for only three of Delaware's 41 new doctors being trained in American medical schools and for only ten of Maine's 121 new doctors being trained in American medical schools. It is partially responsible for the fact that 27.2 percent of all physicians are foreign trained physicians practicing in a 13-county area in northeastern Ohio. Incidentally, there is not a medical school in this 13-county area.

The great majority of internists in Ohio serve as primary physicians for adult patients. I would presume this will continue at least for the next ten years, since adult patients in large communities depend upon the internist for this type of care.

I would like to suggest that the community hospital with proper safeguards could be a superior training ground for general internists rather than the university center with its emphasis on subspecialties and medical research.

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 Double-blind study on the treatment of mentally confused patients. Reprinted  
 from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

## Emergency Room Care Must Be Under Direction of Licensed Physician

In the communication from the State Medical Board, State of Ohio, William J. Lee, Administrator, reported that the following statement is the Board's Position Paper on Emergency Room Care:

"Every patient seen in an emergency room in Ohio must be the medical responsibility of a fully licensed physician (Sections 4731.34 and 4731.41, Revised Code). Physicians in approved training programs who are on duty in the emergency room but who are not fully licensed shall be supervised by a fully licensed physician who is immediately available. The emergency room medical record of each patient must be signed by a fully licensed physician."

## World Medical Association Sponsors European Conference

The World Medical Association is cosponsoring a world Conference on the Human Environment, October 23-26, 1973 in Primosten, Yugoslavia, in collaboration with the Union of Yugoslav Medical Societies, the American Medical Association and the United States Department of Health, Education and Welfare.

This meeting is a follow up on the United Nations Stockholm meeting of June 1972, but because it will be attended by members of the Eastern block (iron curtain) countries who were absent from the earlier meeting for political reasons, it should have a greater impact on international understanding and good will.

There is no registration fee and board and lodging will be under \$10 a day. Registration blanks can be obtained from The World Medical Association, 10 Columbus Circle, New York, N.Y. 10019; or from Mr. Frank Barton, Council on Environment and Public Health of the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

If any physician is interested in associate membership (\$15 a year) in The World Medical Association he can apply to The World Medical Association.

The next annual Assembly will be in Munich, Germany, October 14-20, 1973 just prior to the Primosten conference and will include the 100th Anniversary of the Bundesärztekammer — the German Medical Association.

# NEW economy

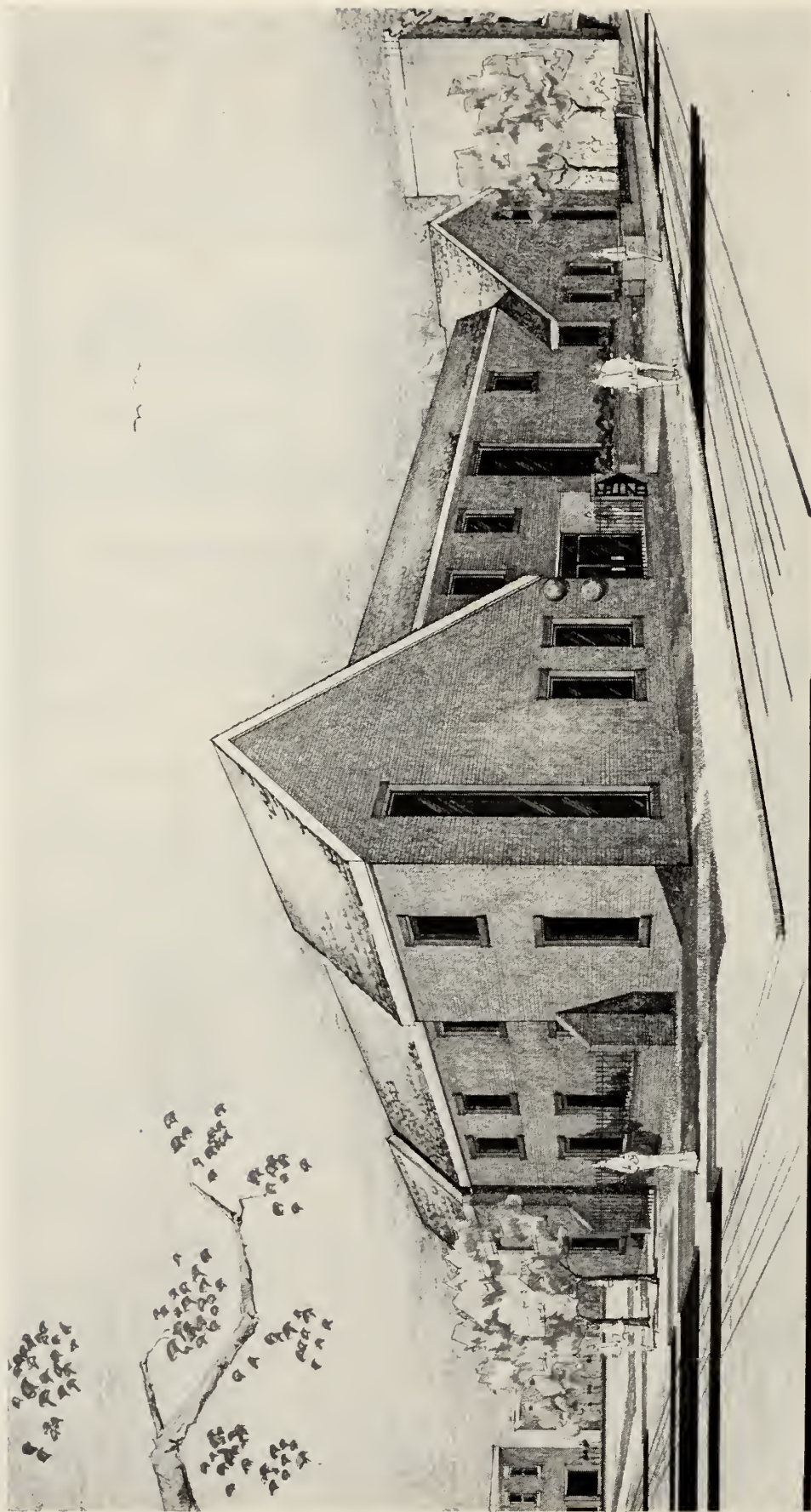
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## Ohio State Medical Association To Occupy Its Own Headquarters Office In the Near Future

BY EARLY 1974, the Ohio State Medical Association's headquarters offices will be housed in the new OSMA building, according to plans now on the architect's drawing boards. In fact, the final plans were approved in principle by the Building Committee at a meeting late in January.

The new property is on the southeast corner of South High Street and Willow Street, on the southern fringe of the Columbus downtown area. The property originally was the site of the historic Bliss Hotel, more recently known as the Midtown Hotel. The old building has been razed and members of the Building Committee are hopeful that construction on the new building will get underway in the very near future.

Opening of the OSMA building will be one more step in development and beautification of the German Village, a large area south of the Columbus downtown area that has undergone considerable restoration in the last decade or more.

The entire exterior of the building — brick walls, windows, gables and roofing effect — will be in keeping with the traditional architecture of the German Village without sacrificing the utilitarian purposes of the structure. Bronzed window frames and decorative wrought iron fence sections will add to the traditional appearance.

The main entrance will be to the west and will be number 610 South High Street. A similar entrance will face east, onto the parking lot that

will accommodate 40 cars. Arrangements are being made for additional parking space near the building to accommodate persons attending evening meetings. More than 17,000 square feet of floor space will be provided on two floors above ground and a full basement.

Officers of the Academy of Medicine of Columbus and Franklin County contemplate the sharing of space in the new building for the Academy offices on the second floor. The Academy would share the board room on the second floor for small meetings and a large meeting room in the basement for larger meetings.

The meeting room on the lower level is spacious enough to seat 120 people. Adjoining facilities will provide for catering service and for refreshments as desired. As the schedule permits, meeting facilities will be made available for other professional groups, such as those of specialty organizations.

The decision to acquire the Association's own building was prompted by inflationary rental costs, especially in the downtown area, and the growing parking problem. Owning its own building is by no means a unique undertaking for the Ohio State Medical Association. Many of the state medical associations own their own buildings. This is also true of the Ohio Academy of Family Physicians, and a number of county medical societies in the metropolitan areas.

## How to Obtain Certain Drugs for Treatment of Parasitic Diseases

The following information recently received from the Center for Disease Control in Atlanta, Georgia, was forwarded to *The Journal* by John H. Ackerman, M.D., deputy director of the Ohio Department of Health, and is printed here for the information of Ohio physicians.

The Parasitic Disease Drug Service of the Center for Disease Control has the following drugs available on an investigational basis. These drugs have been approved by the Food and Drug Administration.

**Pentamidine isethionate:** This drug is effective in the treatment of *Pneumocystis carinii* pneumonia and the early stages of sleeping sickness due to *Trypanosoma gambiense* (see also Mel B and Suramin). *Pneumocystis carinii* pneumonia is a serious infection of neonates, debilitated infants, and children and adults with altered immunological responses (usually in association with a malignancy). African trypanosomiasis is also a potentially serious disease that may affect persons who have lived or traveled through endemic areas in Africa.

**Niclosamide (Yomesan):** This drug is indicated for cestode infections due to *Taenia saginata*, *Hymenolepis nana*, *Diphyllobothrium latum*, and *Dipylidium caninum* (in man). This drug is relatively non-toxic and can be given to ambulatory patients.

**Sodium antimony gluconate (Pentostam)** is a pentavalent antimony compound used in the

treatment of visceral leishmaniasis (kala azar), cutaneous leishmaniasis and mucocutaneous leishmaniasis (espundia). These diseases are widely distributed throughout tropical areas of the world. Pentostam is the only pentavalent antimony compound available in the United States.

**Bithionol, N.F.,** is used in the treatment of disease caused by the lung fluke, *Paragonimus westermani*. In the United States, paragonimiasis affects persons who have resided or traveled in China, South Korea, Japan, Southeast Asia, West Africa, or northwestern South America. The disease is acquired through the ingestion of poorly cooked or freshly-salted crustacean meat or juices and is usually manifested by chronic lung disease, although subcutaneous, cerebral, and abdominal complications can occur.

In addition to the investigational drugs, parenteral chloroquine and parenteral quinine are available. Both of these drugs are licensed and commercially available in the United States, but they have sometimes been difficult to obtain rapidly. Although it is preferable that they be obtained through commercial channels, a supply of both is stocked by the Parasitic Disease Drug Service for emergency use. Parenteral chloroquine is indicated in pernicious *Plasmodium falciparum* malaria in which the strain is sensitive to chloroquine, and parenteral quinine is indicated in pernicious *P. falciparum* malaria in which the strain is resistant to chloroquine. No investigational protocol is necessary for these two drugs.

Request for a drug or drug information should be directed to the Parasitic Disease Drug Service. Telephone numbers in the Atlanta Center are: Days: 404/633-3311, Ext. 3496; and nights, weekends, and holidays: 404/633-2176.



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# Continuing Education Opportunities for Physicians in Ohio

**Surgical Seminars** — Medical College of Ohio at Toledo and Northwestern Ohio Institute for Continuing Medical Education; one hour a day, one day a week, for 88 weeks; dates on request.

**Clinical Days on Emergency Care** — 80 hours of instruction on 20 separate days, September to June; Medical College of Ohio at Toledo, 945 S. Detroit Ave., Toledo 43614.

**Introductory Course in Nuclear Medicine for Physicians** — Nuclear Medicine Institute, 6760 Mayfield Rd., Cleveland 44124; five-day courses; dates upon request.

## March

**Eighth Annual Cancer Symposium** — Akron City Hospital, 525 E. Market Street, Akron 44309; March 14-15.

**Ohio State University College of Medicine, Continuing Medical Education Conferences;** for details contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210:

**Neurochemistry** — March 12-15, Center for Tomorrow

**Neurology Conference** — March 18, Center for Tomorrow

**Pediatrics Clinic Day**, March 21, at Children's Hospital, Columbus

**Dermatology and Allergy** — March 28, Center for Tomorrow

**General Practice Seminar** — March 31-April 1, Center for Tomorrow

**Cleveland Clinic Educational Foundation:**

**Advances in Urology**, March 14-15

**Hodgkins Disease, Leukemia and Lymphoma**, March 21-22

**Treatment of Neurological Diseases**, March 28-29

**Cincinnati VA Hospital Annual Seminar** — March 15, at the hospital, 3200 Vine Street, Cincinnati 45220.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

**Low Renin Hypertension**—Youngstown Hospital Association, South Unit, March 15, 8:00 a.m.; Dr. Randall H. Travis, assistant clinical professor of medicine, Case Western Reserve University.

**Upper Respiratory Infections and Related Diseases**—Youngstown Hospital Association, South Unit, March 26, 4:00 p.m.; Medical Seminar; Drs. R. J. Smith and R. Hoffler.

**Treatment in Psychiatry—Theory and Practice** — at the VA Hospital, 1000 Brecksville Rd., Cleveland 44141; cosponsored by the Northwestern Ohio Institute for Continuing Medical Education and the Medical College of Ohio at Toledo; 49 hours, March 26-30.

## April

**Ohio State University College of Medicine, Continuing Medical Education Conferences;** for details, contact OSU Center for Continuing Medical Education, 410 W. 10th Ave., Columbus 43210:

**Cancer Symposium**, April 4

**Lederle Conference**, April 8

**Sex and Spinal Cord Injuries**, April 12-13

**Plastic Surgery in General Practice**, April 25

**Anesthesia**, April 27

**Myelomeningocele Conference**, April 28-29

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106;

**Current Topics in Clinical Microbiology**, April 4-5

**Peripheral Vascular Disease**, April 25-26

**Orthopaedic Surgery**, April 11-12



## Educational Opportunities in Ohio — *Continued*

**Association of Physicians of the State of Ohio**—Quarterly meeting, Cleveland Psychiatric Institute, April 6; contact Virginia S. Edwards, M.D., Secretary, 347 Lexington Ave., Mansfield 44907.

**The Ladies You Know**—Sheraton-Columbus Motor Hotel, April 8; jointly sponsored by Lederle Laboratories and Ohio Academy of Family Physicians and Ohio State University.

**To Bypass or Not to Bypass**—Youngstown Hospital Association, South Unit, April 9, 4:00 p.m.; Medical Seminar; Drs. J. L. Calvin and R. A. Weiss.

**Chronic Glomerular Disease: Clinical Pathological Correlations and Indications for Treatment**—Youngstown Hospital Association, South Unit, April 19; 8:00 a.m.; Dr. Robert S. Post, associate professor of medicine, Case Western Reserve University.

**Clinical and Laboratory Estimation of Renal Function**—Youngstown Hospital Association, South Unit, April 23, 4:00 p.m.; Medical Seminar; Drs. R. A. Bacani and Y. O. Sheth.

**Genetics in Clinical Practice** — At the Marriott Inn, 2124 S. Hamilton Ave., Columbus, April 24-25; sponsored by Division of Maternal and Child Health, Ohio Department of Health, and Dept. of Pediatrics, Children's Hospital, Columbus; guest speakers, Dr. Howard Pearson, Yale University; Dr. David Smith, University of Washington; and Dr. Henry Nadler, Children's Memorial Hospital, Chicago. Contact, Stella B. Kontras, M.D., Children's Hospital, Columbus 43205; phone 614/253-8841, ext. 254.

**Family Relations Workshop**—April 27-29 at Salt Fork Lodge, Cambridge; sponsored by Ohio Academy of Family Physicians.

### May

**University of Cincinnati College of Medicine (CONMED)**—Eden and Bethesda Avenues, Cincinnati 45219:

**Velo-Pharyngeal Insufficiency**, May 3

**General Surgery**, May 16-17

**Internal Medicine — Current Concepts of Clinical Problems**—Cosponsored by the American College of Physicians, May 21-25

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106:

**Organization and Administration in Anesthesiology**, May 5-6

**Advances in Dermatology**, May 9-10

**Newborn Conference**—Ohio State University College of Medicine, May 2-3, at the Center for Tomorrow; contact OSU Center for Continuing Medical Education, 410 W. Tenth Ave., Columbus 43210.

**Gynecologic Endoscopy** — St. Luke's Hospital, 11311 Shaker Blvd., Cleveland 44104; May 2-3; and **Recent Advances in Reproductive Physiology**, May 4; contact Amir H. Ansari, M.D., at the hospital, phone 216/791-1000, ext. 360.

**Endoscopy and Gastrointestinal Bleeding**—Youngstown Hospital Association, South Unit, May 17, 8:00 a.m.; Dr. Reed T. Keller, of Case Western Reserve University, guest lecturer.

**Cleveland Society of Obstetricians and Gynecologists**—Educational forum at the Cleveland Clinic; March 14, 3:00-6:00 p.m.; topics, Stress Incontinence, Ultrasonic Diagnosis, Placental Morphology, Cytohormonal Analysis; speakers, Dr. Peter Beck, University of Alberta; Dr. H. I. Perlmutter (Ph.D.), Dr. S. Aladjem, Dr. A. H. Ansari, and Dr. C. R. Cowdrey; 6:30 dinner meeting at the University Club, with Dr. Beck speaking on "Surgical Anatomy of Stress Incontinence and Pelvic Malignancy." Contact Kathryn Hoffman, M.D., 806 Rose Bldg., Cleveland 44115.

**Research in Esophageal Repair**—Veterans Administration Center, 4100 W. Third Street, Dayton 45428; May 18; 2:30 p.m.; Dr. Charles L. Cogbill; **A New Approach in the Treatment of Esophageal Perforation**, Dr. Krishna V. S. Rao; **A New Treatment for Esophageal Stricture**, Dr. Mahood Mir.

**Internal Medicine, Current Concepts of Clinical Problems**—Sponsored by the American College of Physicians and the University of Cincinnati College of Medicine; May 21-25 at the Medical Center, Cincinnati.

**Digitalis and Injured Heart**—Youngstown Hospital Association, South Unit, May 28, 4:00 p.m.; Drs. W. H. Bunn, Jr., and R. D. Arnott.

**Refresher Course in Diagnostic Roentgenology, 15th Annual** — Radiology Dept., University of Cincinnati College of Medicine, under direction of Benjamin Felson, M.D., May 29 - June 2; for radiologists and radiology residents; contact Dr. Harold B. Spitz, Dept. of Radiology, Cincinnati General Hospital, Cincinnati 45229.

*(Continued on Next Page)*

# St. Elizabeth Hospital, Youngstown, Announces Continuing Education Courses

## March

Dept. of OB-Gyn Visiting Professor Series: **Functional Anatomy of the Pelvis**, Henry Perlmutter, Ph.D., March 15; **Chromosomal Abnormalities and Counseling**, Neil MacIntyre, Ph.D., March 22.

Dept. of Surgery Grand Rounds: **Pancreatitis and Pseudocysts**, Robert Hritz, M.D., March 15; **Carcinoid Tumors**, Rashid Abdu, M.D., March 22; **Portal Hypertension**, Felix Pesa, M.D., March 29.

Family Practice: **G. I. Bleeding**, Drs. M. Vuksta and J. Gregori, March 16; **A Jaundiced Baby**, Dr. K. Wegner, March 23; **ENT Emergencies**, Dr. J. R. Sofranec, March 30.

Dept. of Pediatrics and CORE Conference: **Examination of the Newborn and Well Baby Care**, Kurt Wegner, M.D., March 21.

The Clinical Examination: **Ventricular Arrhythmias**, L. P. Caccamo, M.D., March 14; **Bundle Branch Block**, Dr. Caccamo, March 28.

Dept. of Medicine Hematology Conferences: **Chronic Myelogenous Leukemia**, Dr. Westerman, March 19.

Dept. of Medicine Grand Rounds: **Cerebral Giantism**, Dr. Y. Jung, March 13; **Myasthenia Gravis**, Dr. Firestone, March 20; **CPC**, Drs. Saadi and Taylor, March 27.

Dept. of Medicine, Visiting Professor Series: **Drug Overdose**, Robert McDonald, M.D., March 22; **Acute Hepatitis with Cirrhosis of Liver in Nonalcoholic Patient**, George J. Gabuzda, M.D., March 29.

Department of Medicine G. I. Conferences: **Lactose Intolerance**, Dr. Gregori, March 13; **Anatomy and Physiology of Small Bowel**, Dr. Gaylord, March 20; **Regional Enteritis**, Dr. Gregori, March 27.

Dept. of Medicine Endocrinology Conferences: **Hyponatremia**, Dr. Jung, March 17; **Inappropriate ADH Syndrome**, Dr. Jung, March 24; **Thyroid Adenoma**, Dr. Jung, March 31.

Tumor Conferences (Surgery): **Ca of Bile Duct and Pancreas**, Dr. George River,

March 15; **Ca of Thyroid, Pancreas, Stomach**, Dr. Riber, **Hodgkin's Disease, Acute Myeloblastic Leukemia, Multiple Myeloma, Scirrous Carcinoma of Breast**, Dr. Riber, March 29.

Dept. of Anesthesia: **Physiology of Spinal and Epidural Anesthesia**, Dr. Salcedo, March 15; **Anatomy and Technique of Spinal and Epidural Anesthesia**, Dr. Salcedo, March 22; **The Vasopressors**, Dr. Lee, March 29.

## April

Dept. of OB-Gyn Visiting Professor Series: **Current Concepts in OB Anesthesia**, Carl Redderson, M.D., April 5; **Impact of Venereal Disease in OB-Gyn**, Delbert Booher, M.D., April 12; **Premalignant and Malignant Lesions of Vulva and Vagina**, W. B. Wentz, M.D., April 19; **Treatment of Uterine Cancer — Cervix and Corpus**, Dr. Wentz, April 26.

Department of Surgery Grand Rounds: **Diabetic Gangrene**, Demetrios J. Dallis, M.D., April 5; **Venous Diseases of the Lower Extremities**, Robert Hritz, M.D., April 12; **Zollinger - Ellison Syndrome**, Rashid Abdu, M.D., April 19; **Shock**, Felix Pesa, M.D., April 26.

Family Practice: **Most Common Endocrine Disturbances, Exclusive of Diabetes and Thyroid Disease**, Dr. W. Cleary, April 6; **Management of Coronary Occlusion**, Dr. L. Caccamo, April 13; **Stroke and Rehabilitation**, Dr. Gilliland, April 20; **Diuretics and Their Uses**, Dr. E. Kessler, April 27.

Dept. of Pediatrics and CORE Conferences: **Immunization**, Kurt Wegner, M.D., April 4; **Poisoning in Children**, Dr. Wegner, April 18.

The Clinical Examination: **Leads**, L. P. Caccamo, M.D., April 11; **Anatomical (X-Ray) and Electrical (ECG) Positions of the Heart**, Dr. Caccamo, April 25.

Dept. of Medicine Hematology Conferences: **Pancytopenia with a Hypercellular Marrow of Undetermined Etiology**, Dr. Jensen, April 9; **Leukemoid Reaction**, Dr. Westerman, April 23.

*(Continued on Next Page)*

## Educational Opportunities in Ohio — *Continued*

### St. Elizabeth Hospital, Youngstown (Contd.)

Dept. of Medicine Grand Rounds: Liver Cirrhosis, Dr. Tiberio, April 10; Hypercalcemia, Dr. Cleary, April 17; Audit Conference, Dr. Saadi, April 24.

Dept. of Medicine Visiting Professor Series: Workup of Acute Arthritis, Thomas A. Medsger, M.D., April 12; Rheumatic Heart Disease with Mitral Valve Disease, James J. Leonard, M.D., April 26.

Dept. of Medicine G. I. Conferences: G. I. Bleeding, Dr. Gaylord, April 17; Steatorrhea, Dr. Gregori, April 24.

Dept. of Medicine Endocrinology Conferences: Aldosteronism, Dr. Jung, April 7; Turner's Syndrome, Dr. Jung, April 14; Acromegaly, Dr. Jung, April 21; Graniopharyngioma with Hypopituitarism, Dr. Jung, April 28.

Tumor Conference (Medicine): Adenocarcinoma, George River, M.D., April 5; Stage IV Serous Cystadenoma of Ovaries, Osteogenic Sarcoma Left Distal Femur, Ulcerating Carcinoma of Stomach, Stage IV Breast Carcinoma, Dr. River, April 12; Myeloblastic Leukemia, Cancer of Breast, Colon, Head of Pancreas, Dr. River, April 19; Metastatic Ca (Primary?), Ca of Stomach, Myelofibrosis, Urinary Bladder Ca, Dr. Riber, April 26.

Dept. of Anesthesia: The Endocrines and Anesthesia, Dr. Lee, April 5; The Autonomic Nervous System, Dr. Dziadzka, April 12; Hyperthermia and Hypothermia, Dr. Richards, April 19; Obstetrical Anesthesia, Dr. Malta, April 26.

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*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

**Are there significant  
differences in bioavailability  
and clinical predictability  
among drug products?**

# Opinion

**Results of a questionnaire to  
7,000 physicians:**

**44.6%**

**Agree there is a significant  
difference**

**24.9%**

**Believe there is no difference**

**30.5%**

**Had no opinion**

# Are there significant differences in bioavailability and clinical predictability among drug products?

## Teacher of Medicine

Alfred Gilman, Ph.D.  
Wm. S. Lasdon  
Professor & Chairman  
Department of  
Pharmacology  
Albert Einstein  
College of Medicine of  
Yeshiva University



I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

### The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

### It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equivalent

lency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

### The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and bioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

### Clinical Predictability More Important Than Price

Although the question of price has been greatly exaggerated, it is true that patients can on occasion save money on generic drugs. But you are not going to dare attempt to save money if it jeopardizes the patient's health. Let's return to the example that has become very prominent in recent years, that of the cardiac glycosides. These are probably the most toxic drugs we use with respect to the small difference between a maximally effective dose and a toxic dose. When you are dealing with drugs of this type, the first concern must be clinical predictability. At the risk of variations in bioavailability, it would be sheer folly to try to save the patient what might amount to maybe \$10 or \$20 a year. The physician cannot manage his patient unless he is sure that the drug he is prescribing has the same positive effect each time the prescription is renewed. This is especially significant when the patient takes the product, not for months but for the rest of his life.

## Maker of Medicine

C. J. Cavallito, Ph.D.  
Executive Vice President  
Ayerst Laboratories



Although equivalence of different preparations of a drug substance may be determined by certain physical, chemical or biological characteristics, identity is not always assured even though these characteristics may be described in compendia such as the USP, NF or defined by other specific reference standards. Moreover, even with equivalent drug substances, similar pharmaceutical products can be produced by different manufacturers such that these products are bioequivalent or therapeutically equivalent.

Growing Awareness of Potential for Nonequivalence  
As experience increases in drug substances derived from different sources under different conditions, it should be possible to establish specifications in sufficient detail to minimize the potential for their nonequivalence. However, there is general agreement that product therapeutic equivalence would still not be assured even if one could

minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

### Newer Bioavailability Studies Reveal Differences

Bioavailability may be defined as a measure of the rate and amount of absorption of a drug substance from its administered dosage form. For several years pharmaceutical scientists have proposed that bioavailability data on presumably equivalent dosage forms provide the best measure of product equivalence—short of adequate clinical trial. In their continued search for shortcuts to the evaluation of product equivalence, medical and pharmaceutical scientists have increasingly relied upon bioavailability characteristics as reflected by blood levels of a drug after its administration to human subjects.

Leading manufacturers now conduct comparative bioavailability studies on their own product dosage forms after production process changes that would have been considered inconsequential a few years ago. This isn't surprising, since there are so many possible differences in production operations that the opportunities for inequiva-

lent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalence have appreciably improved.

### Product Selection

Based on Patient Response  
Improved specifications and standards can better assure the equivalence of drug substances. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the drug product, not the drug substance, that the physician, pharmacist, nurse and patient-customer utilize. How can these indi-

viduals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

### Reputation of Manufacturer as Basis for Product Selection

The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

## Opinion & Dialogue

What is your opinion, doctor?  
We would welcome your comments.



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**Temperature:** 102° F

**Therapy:** MINOCIN Minocycline HCl Capsules, 100 mg: 200 mg *stat*, 100 mg every 12 hours. Medication began 9/7/71. By fourth day, temperature was normal and pustular lesions considerably improved. Last dose taken 9/14/71.

**Concomitant therapy:** None.†



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**Contraindications:** Hypersensitivity to any tetracycline.

**Warnings:** The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. Photosensitivity manifested by an exaggerated sunburn reaction has also been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity does not occur with MINOCIN Minocycline HCl. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN, leading to azotemia, hyperphosphatemia, and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug.

**Pregnancy:** In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. Safety of use during human pregnancy has not been established. **Newborns, infants and children:** All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease

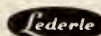
in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

**Precautions:** Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Because tetracyclines have been shown to depress plasma prothrombin activity, patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

**Adverse Reaction:** GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. **Skin:** maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). **Renal toxicity:** rise in BUN, dose-related (see "Warnings"). **Hypersensitivity reactions:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. **Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. **CNS:** (see "Warnings.") When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**NOTE: Concomitant therapy:** Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

\*Indicated in infections due to susceptible organisms. Culture and sensitivity testing recommended. Tetracyclines are not the drugs of choice in the treatment of any staphylococcal infection. †Case Report, Clinical Investigation Department, Lederle Laboratories.



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## Abstracts from Regional Meeting of American College of Physicians

**EDITOR'S NOTE:** Again this year *The Journal* is pleased and proud to publish abstracts of the papers read at the Combined Regional Meeting of the American College of Physicians for Ohio, West Virginia, and Western Pennsylvania, October 13-14, 1972 at the Heart of Town Motel, Charleston, West Virginia. The abstracts present in concise form a wealth of information reflecting the nature of current medical research in this part of the country. We are indebted to Dr. John E. Jones and his Program Committee for the selection of the papers and to them and Drs. Jack H. Baur, William H. Bunn, Jr., and Donald W. Bortz, Governors of the College for West Virginia, Ohio, and Western Pennsylvania, respectively, for permission to publish the abstracts.

\* \* \*

### A Study of the Cause of Hypoproteinemia and Hypoalbuminemia in Trichinosis

George D. Ludwig, M.D., F.A.C.P., and  
Roberto Franco, M.D., Toledo, Ohio

Hypoproteinemia, especially hypoalbuminemia, was first reported as a complication of trichinosis in 1936. Despite 14 subsequent publications which established a relationship between the severity of hypoalbuminemia and trichinosis, the cause remains obscure. Mild proteinuria; inanition caused by anorexia, vomiting, and diarrhea; increased protein demands for muscular regeneration; and defective albumin synthesis due to liver damage have been implicated. Our studies of albumin turnover, using  $\text{Cr}^{51}$ -labeled albumin, in a

severe case of trichinosis provided evidence of protein-losing enteropathy. Biochemical evidence of hepatic damage along with extensive infiltration of hepatic cells with fat was demonstrated.

A 32-year-old woman developed typical clinical signs and symptoms of trichinosis with eosinophil count of 70 percent. Diarrhea began during the first week and persisted for six weeks. Trichinosis was confirmed by a highly positive bentonite flocculation test, countercurrent electrophoretic precipitin test, and a gel diffusion test. Total protein was 3.7 gm per 100 ml with albumin 1.3 to 1.5 gm per 100 ml in repeated electrophoretograms. Roentgenograms showed slight edematous changes in the jejunum, but jejunal biopsy two weeks later showed normal mucosa and villi.

Urinary protein excretion was only 125 mg/24 hr. Various hormonal binding proteins were also low, including transferrin, ceruloplasmin, and TBG. Suspecting protein-losing enteropathy, we injected  $30\mu\text{Ci}$  of  $\text{Cr}^{51}$ -labeled albumin intravenously at 8 AM and obtained blood samples at 15 minutes and each succeeding morning for ten days. Each 24-hour urine sample was collected separately and feces were collected in two successive 96-hour pools. The  $T_{1/2}$  of albumin disappearance from plasma was nine days for the patient (normal 13 to 20 days); the rate of albumin turnover 13.8 percent (normal 6.6 percent); and the albumin degradation 33 gm (normal 12 to 15 gm). These kinetic data are characteristic of protein-losing enteropathy. Despite the extensive liver impairment, albumin synthesis must have been sufficient to maintain an equilibrium in the plasma in the face of such increased losses. These studies offer for the first time a concrete explanation for the severe hypoproteinemia-hypoalbuminemia that frequently accompanies trichinosis. Thiabendazole (Mintezole®) evoked dramatic clinical improvement.

\* \* \*

#### Hirschsprung's Disease Occurring in Only One of Monozygotic Twins

R. Simonsen, M.D., R. Smith, M.D., and D. Lareau, M.D. (Associate), Warren, Pennsylvania

Radiographs and postoperative pathology reports prove aganglionic megacolon in one of twin boys whose twin brother has no symptoms and a normal barium enema. Besides identical appearance, blood-typing report reduces chance of non-monozygosity to less than one in many millions. No similar case has been reported previously. This suggests that intra-uterine environmental interference can be a cause of neural defect rather than only genetic inheritance. A brief review of pertinent literature was included.

\* \* \*

#### Changes of Gastrointestinal System as Sequelae of Diabetes Mellitus

C. Robert Tittle, Jr., M.D., F.A.C.P., Toledo, Ohio

The important effects of gastrointestinal disease on diabetes mellitus have been fully described. The present communication will consider the effects of diabetes mellitus on the gastrointestinal tract. First, we cannot exclude the acute abdominal pain and vomiting associated with diabetic keto-acidosis which are well recognized, of short duration, and reversible with proper treatment.

The diabetic has characteristic intra-oral symptoms helpful in diabetic detection, and characteristic dental symptoms include advanced periodontal disease, especially pyorrhea alveolaris, and alveolar bone resorption. Asymptomatic parotid gland enlargement is not infrequent in diabetes. Recurrent effortless regurgitation with associated dysphagia may represent autonomic neuropathy involving the esophagus. Gastroparesis diabeticorum may occur with or without diabetic enteropathy. Diabetic cholecystomegaly may occur with no cholelithiasis or clinical gallbladder dysfunction. Hepatic dysfunction is relatively rare in diabetes but hepatomegaly may occur in uncontrolled diabetes, hemochromatosis, lipoatrophic diabetes, and in males with associated hepatic cirrhosis.

Pancreatic exocrine disease is often associated with diabetes in pancreatitis, carcinoma, and hemochromatosis. Diabetic diarrhea is a manifestation of autonomic neuropathic intestinal hypoactivity with resultant stasis and a blindloop syndrome mediated through nonspecific bacterial overgrowth. Constipation commonly alternates with diarrhea owing to small bowel hypoactivity plus gross dilatation of descending colon and rectum.

\* \* \*

#### Alkaline Phosphatase Isoenzymes in Hepatobiliary Diseases and Thyrotoxicosis

Stuart Chen, M.D., F.A.C.P., and William Anderson, M.D., Morgantown, West Virginia

Serum alkaline phosphatase isoenzymes have been shown to be organ specific, deriving from the liver, bone, intestine, and placenta. The present study was undertaken to investigate the isoenzyme distribution in patients with hepatobiliary disease and thyrotoxicosis. Canalco disc electrophoresis was performed on 1,000 consecutive sera with the enzyme values of 100 mμ/ml or more by auto-analyzer technique (normal: 30 to 85 mμ/ml). 25 μl undiluted serum was employed. The relative color intensity (RCI) of isoenzyme bands was visually graded and was found reproducible. Serum alkaline phosphatase was satisfactorily separated into four bands: liver, bone, intestine, and bile. One thousand sera were collected from 594 patients. Seventy-seven cases had hepatobiliary diseases, ie, alcoholism, 23 cases; chronic active hepatitis, 15 cases; Laennec's and post-necrotic cirrhosis of the liver, 24 cases; viral hepatitis, 16 cases; extrahepatic obstructive jaundice, 10 cases. Liver band was found in all cases. Intestinal band was identified in 2 of 13 cases (15 percent) of alcoholism; 4 of 15 cases (27 percent) of chronic active hepatitis; 9 of 24 cases (38 percent) of cirrhosis; 3 of 16 cases (19 percent) of

viral hepatitis but none in extrahepatic obstructive jaundice. Bile band was identified in 2 of 13 cases (15 percent) of alcoholism; 5 of 15 cases (33 percent) of chronic active hepatitis; 4 of 24 cases (17 percent) of cirrhosis; 5 of 16 cases (31 percent) of viral hepatitis; and 6 of 10 cases (60 percent) of extrahepatobiliary obstruction. Identification of intestine and bile bands by serum electrophoresis may be of value in distinguishing between hepatocellular and extrahepatic biliary disease.

Elevation of serum alkaline phosphatase (SAP) activity has been frequently demonstrated in thyrotoxicosis. The source has been assumed to be related to impaired liver function or to increased bone resorption.

Twelve consecutive cases of hyperthyroidism with elevated SAP were studied. All except one had Graves' disease. The ages ranged from 18 to 63 years with mean age of 38 years. There were nine women and three men. Mean serum alkaline phosphatase was 174 mμ/ml (normal: 30 to 85 mμ/ml). Mean PBI was 13.0 μg%; mean T<sub>4</sub>I, 9.7 μg%; mean T<sub>3</sub> uptake, 43.3%, and mean <sup>131</sup>I uptake, 68%.

Both bone and liver isoenzymes were present in all 12 patients with thyrotoxicosis, whereas the former was usually absent in the normal adults. The RCI of bone band exceeded that of liver band in 8 out of 12 patients. SAP study was repeated in five patients after successful control of thyrotoxicosis. Four patients were treated with propylthiouracil (PTU) and one with <sup>131</sup>I. After one to nine months of PTU, SAP remained elevated in four and bone band unchanged in three of the four. SAP rose significantly after <sup>131</sup>I therapy in one patient. Elevations of SAP in thyrotoxicosis is related to increased bone turnover. Persistent elevation of SAP after treatment probably indicates continued osteoblastic hyperactivity.

\* \* \*

Catabolism of Heme by Human  
Spleen Preparations

Peter White, M.D., Paul R. Garrett, M.D., and  
Kathleen L. Andrews, Toledo, Ohio

Recent studies have established that physiologic catabolism of hemoglobin to bile pigment is accompanied by the production of carbon monoxide (CO), which arises stoichiometrically from the porphyrin ring of heme. Patients with hemolytic states or ineffective erythropoiesis have elevated rates of endogenous CO production, but uncertainties persist regarding the reliability of CO production for clinical measurement of hemoglobin degradation. Turnover of hepatic heme compounds also contributes to CO production, and

non-CO pathways may mediate heme catabolism under some conditions. To clarify the biochemical pathways involved in heme catabolism, therefore, we have studied the in vitro conversion of hemin-<sup>14</sup>C to <sup>14</sup>CO by human reticuloendothelial tissue.

Spleens removed at surgery were homogenized in sucrose; cellular fractions were then prepared by differential centrifugation and incubated with hemin-<sup>14</sup>C at pH 7.4. Following incubation, the <sup>14</sup>CO produced was passed through a reaction train and oxidized by Hopcalite to <sup>14</sup>CO<sub>2</sub> for trapping and counting. In 30-minute incubations, significant <sup>14</sup>CO was generated by microsomal fractions from 10 to 11 spleens studied in amounts corresponding to the catabolism of 0.5-2.3 nanomoles hemin/mg microsomal protein. Oxygen and NADPH were required for optimal activity; inhibition was seen with high partial pressures of unlabeled carbon monoxide in the incubation flasks or with 2-diethylaminoethyl-2, 2 diphenylvalerate (SKF525A). Lesser amounts of <sup>14</sup>CO were produced by the mitochondrial fraction, but the supernatant (cell sap) fraction was devoid of activity. In duplicate incubations, bilirubin production (determined by absorbance at 468 nm) paralleled CO production. These results are consistent with the concept proposed by Tenhunen that heme catabolism is mediated by a microsomal mixed function oxygenase system. In spleens from two patients with hemolytic disease, microsomal activity was not increased above that seen in normals, suggesting the enzyme induction does not accompany hemolysis.

\* \* \*

Cumulative Hematologic Toxicity to  
1-(2-Chloroethyl)-3-Cyclohexyl-1-Nitrosurea  
(CCNU): A Case Report

Richard L. Meyer, M.D., F.A.C.P., Cincinnati, Ohio

CCNU is a lipid soluble oncolytic agent that has been shown to have activity against human gliomas. The agent's major toxicity is delayed bone marrow suppression. Dose limiting marrow toxicity occurs within four to six weeks. Cumulative toxicity has not been demonstrated.

This 7-year-old boy had biopsy-proven astrocytoma of the hypothalamus established on March 5, 1971. He received 800 rads of <sup>60</sup>Co to the hypothalamus before therapy was discontinued because of increased intracranial pressure. A ventricular-peritoneal shunt controlled this complication. The patient was given 80 mg CCNU (130 mg/m<sup>2</sup>) orally on May 3, June 15, August 2, September 24, and November 2, 1971, as an outpatient. Prior to receiving chemotherapy, his white blood cell count was more than 5000 per



cu mm; platelet count was more than 100,000 per cu mm; hematocrit value was more than 30 percent.

The patient was seen on November 16, 1971 and was started on <sup>60</sup>Co to the hypothalamus through 8 cm X 8 cm port. Blood counts performed on November 18, 1971 disclosed pancytopenia. Physical examination did not disclose any adenopathy, splenomegaly, or ecchymosis. Bone marrow aspirate demonstrated depressed maturation of the marrow components, especially megakaryocytes. He had not received any other medication or been exposed to marrow depressants. The patient has required frequent transfusions and supportive care with no improvement in peripheral blood counts.

This case is believed to demonstrate cumulative hematologic toxicity to one of the nitrosureas, a group of active chemotherapeutic agents.

\* \* \*

**Automated Blood Counts in the Diagnosis  
of Thalassemia Minor**

**Richard E. Nensel, M.D., and George C. Hoffman,  
M.D., F.A.C.P., Cleveland, Ohio**

Beta thalassemia minor, the heterozygous form of thalassemia associated with reduced production of the  $\beta$  globin chains, is generally considered to result in mild hypochromic microcytic anemia. The distinction from iron deficiency anemia is usually based on the increased Hb-A<sub>2</sub> (or less frequently Hb-F) and normal serum iron level present in thalassemia minor. The diagnosis is seldom considered in persons with normal hemoglobin levels. We have been surprised at the number of patients with beta thalassemia minor whom we have detected since an automated cell counter (Coulter Model S) has been in use for all blood counts. Twenty-one out of 26 patients with beta thalassemia minor (as judged by an increased Hb-A<sub>2</sub>) had a blood hemoglobin content greater than 12.5 gm per 100 ml. The disorder was suspected because of an erythrocytosis (RBC count greater than  $6 \times 10^6$ /c.mm) with microcytic hypochromic red cells. The diagnosis of beta thalassemia in many other patients, in whom mild anemia was present, was also facilitated by the finding of mild erythrocytosis not in association with iron deficiency.

\* \* \*

**Bone Marrow Involvement in Hodgkin's Disease**

**R. B. Weiss, M.D. (Associate), Morgantown, West  
Virginia, and B. J. Kennedy, M.D., F.A.C.P.,  
Minneapolis, Minnesota**

An important procedure in the initial staging and for subsequent evaluation of Hodgkin's disease is trephine bone marrow biopsy. Twenty-nine patients with Hodgkin's disease, seen from 1960 to the present, were found to have bone marrow involvement. Twenty-three had Reed-Sternberg cells in the marrow biopsy, and the remaining had the otherwise typical cellular infiltration of Hodgkin's disease. Twelve patients had marrow involvement at the time of diagnosis of Hodgkin's disease, and 17 patients had it later in the disease course. At the time of the positive marrow biopsies, 25 had anemia and 13 had pancytopenia. All patients had fever and many had multiple lymph node, liver, and spleen involvement.

At the time of the original diagnosis of Hodgkin's disease in these patients, 16 of the lymph node biopsies that could be classified had mixed cellularity histologic type. Twenty-two patients were staged as III or IV disease at the onset, including the 12 who were stage IV because of the positive marrow. The age at onset of the Hodgkin's disease was over 35 years in 22 patients.

Median survival of patients after discovery of a positive marrow was short. Twelve patients received a four-drug combination therapy. Four went into complete remission.

Those patients with Hodgkin's disease, who are older than 35 years, and who have mixed cellularity histologic type, fever, stage III or IV disease clinically and pancytopenia are likely to have bone marrow involvement. Only aggressive combination chemotherapy results in complete remission.

*Supported by Public Health Service training grant CA-05158.*

\* \* \*

**Paternity Exclusion Tests  
A Neglected Tool in Family Counseling**

**John W. King, M.D., F.A.C.P., Cleveland, Ohio**

In view of our ever-changing standards of sexual morality, the family physician may be faced with medical and emotional problems stemming from the departure of the younger members of the family from the accepted sexual mores of the older generation. When such activity brings on an unwanted pregnancy, it is frequently necessary to determine the paternity of the child. This is

a legal decision rendered by the Courts, but laboratory help is available to help exclude the innocent man. A review of our series of 800 blood tests indicates that about one-third of such accused men are not the father of the child in question. The technics for doing these tests are simple ones and are not beyond the capabilities of the good clinical laboratory.

The theoretical exclusion rate, using five blood group systems, is 55 percent. Our experience with bastardy cases shows an actual exclusion rate of 15 percent. On the other hand, the exclusion rate in divorce cases is nearly 50 percent, indicating that men rarely accuse a wife of infidelity unless there is a very good reason to do so. There is a higher exclusion rate for cases involving black patients as opposed to white patients. This is contrary to theoretical expectations, inasmuch as there is a greater uniformity of blood group antigens among black people than among more mongrelized urban American whites. The difference can then be ascribed to differences in social habits or other less defined factors.

The use of the sickle-cell gene and red-cell enzyme were discussed as possible additions to paternity exclusion practices.

\* \* \*

#### Plasma Testosterone Binding Determination in the Evaluation of Hirsute Women

John E. Jones, M.D., F.A.C.P., Morgantown, West Virginia

To assess possible abnormalities of plasma androgen levels in hirsute women, the following studies have been done: immunoassay of plasma testosterone (T) and androstenedione (A); "free T" (FT) by equilibrium dialysis of plasma against saline; "free testosterone index" (FTI) by a plasma-charcoal assay; and the plasma albumin binding ratio (BR) of T by equilibrium dialysis of plasma against albumin. Mean  $\pm$  s.d. values in normal women were: T  $34 \pm 11.5$  ng% (n=48); A  $170 \pm 64$  (n=28); FT  $0.3 \pm 0.2$  ng% (n=15); FTI  $9.9 \pm 5$  (n=15); BR  $5.3 \pm 1.5$  (n=16). Mean values in hirsute women were: T  $62 \pm 36$  ng% (n=62); A  $270 \pm 114$  ng% (n=52); FT  $1.4 \pm 1.3$  ng% (n=17); FTI  $25.9 \pm 19$  (n=49); BR  $2.5 \pm 0.8$  (n=16). While the two groups were statistically different at the 0.1 percent level, plasma T was elevated in only 37 percent, and A in 40 percent of the hirsute women. In contrast, FT was elevated in 60 percent of the hirsute women. The correlation coefficient between % T bound by the FT and FTI methods was 0.93 (p<.001). These results demonstrate both reduced plasma T binding and elevated FT in the majority of hirsute women. The determina-

tion of either the FT or FTI more frequently suggests abnormalities in women with hirsutism than either T or A determinations alone.

\* \* \*

#### Glucose Arterial-Venous (AV) Differences Across Muscle in McArdle's Disease

Charles E. Turner, M.D., F.A.C.P., and Christine Waterhouse, M.D., F.A.C.P., Huntington, West Virginia

Studies of glucose arterial-venous (AV) differences across skeletal muscle in patients with McArdle's disease (myophosphorylase deficiency) demonstrated normal values during mild exercise even though no increase in venous lactate could be found. Thus, substrate availability appeared not to have exceeded the capacity for aerobic metabolism. In contrast, low AV differences of glucose were present with ischemic exercise. These data support the thesis that phosphorylase activity within skeletal muscle is essential to allow for adequate glycolysis with ischemic work and that excess glucose and circulating insulin provide insufficient intracellular glucose for this purpose. We interpret the diminished membrane transport of glucose under this condition as secondary to altered cell function.

These studies offer an explanation for the inability of patients with McArdle's disease to maintain sustained strenuous exercise despite the availability of adequate circulating glucose.

\* \* \*

#### Effect of Transfusion of Stored Blood on Oxygen Delivery in Acidosis

James P. Mondzelewski, M.D.; Jerry T. Guy, M.D.; Philip A. Bromberg, M.D., F.A.C.P.; and Stanley P. Balcerzak, M.D., F.A.C.P., Columbus, Ohio

Blood stored in ACD develops increased oxygen affinity secondary to a progressive loss of red cell 2,3 diphosphoglycerate (DPG). Our previous work in recipients with normal blood pH has shown that transfusion with ACD-stored blood impairs tissue oxygenation in rats and does not promptly improve it in humans. Because acidosis may be present in patients transfused with large quantities of blood and since pH affects oxygen affinity and glycolysis, oxygen delivery was studied in acidotic, exchange-transfused rats. Experimental animals (group I) were transfused with blood stored in ACD for seven days. One control group (II) was exchanged with fresh blood collected in ACD; a second control group (III) was not transfused. DPG values for stored and fresh donor blood were  $1.6 \pm 0.6$  and  $21.5 \pm 2.3$

| Tests                  | Group | Time After Exchange |   |             |             |            |             |
|------------------------|-------|---------------------|---|-------------|-------------|------------|-------------|
|                        |       | Pre-x               | 5 Min.  | 1 Hr.       | 4 Hr.       | 9 Hr.      | 24 Hr.      |
| DPG                    | I     | 19.6 ± 2.7          | 3.8 ± 1.8*  | 5.0 ± 1.2*  | 7.1 ± 1.1*  | 9.1 ± 2.1* | 9.7 ± 3.8*  |
| ( $\mu$ moles/<br>gHb) | II    | 16.4 ± 3.4          | 18.4 ± 2.6  | 17.0 ± 2.4  | 17.3 ± 3.1  | 14.7 ± 1.8 | 15.5 ± 4.9  |
|                        | III   | 18.6 ± 3.2          |   | 16.7 ± 3.1  | 17.5 ± 2.5  | 14.3 ± 2.1 | 11.7 ± 1.0* |
| P <sub>50</sub>        | I     | 29.6 ± 1.9          | 19.1 ± 0.5*   | 19.6 ± 1.1* | 22.6 ± 1.4* | 25.4 ± 2.0 | 23.1 ± 1.8* |
| (mmHg)                 | II    | 27.1 ± 4.0          | 26.8 ± 3.1  | 28.7 ± 3.2  | 28.8 ± 1.0  | 28.8 ± 3.4 | 25.4 ± 1.9  |
|                        | III   | 31.0 ± 2.2          |   | 29.0 ± 2.2  | 30.1 ± 2.9  | 27.2 ± 1.4 | 24.8 ± 2.9* |
| PSBO <sub>2</sub>      | I     | 33.1 ± 4.8          | Pre-x refers to values obtained 3.5 hrs.<br>after induction of acidosis but prior to<br>actual or sham transfusion. |             |             |            | 23.9 ± 3.8* |
| (mmHg)                 | II    | 32.6 ± 5.4          |   |             |             |            | 35.2 ± 8.5  |
|                        | III   | 31.8 ± 2.2          |   |             |             |            | 36.4 ± 2.9* |

\*P<0.05 compared with pre-x.

$\mu$ moles/gHB respectively. Corresponding oxygen affinity (P<sub>50</sub>) values were 18.1 ± 0.6 and 28.9 ± 1.6 mmHg. Acidosis was induced with NH<sub>4</sub>Cl 3.5 hours prior to study and pH was maintained between 7.08 and 7.26. Arterial blood gases, pH, red cell DPG, P<sub>50</sub>, and hematocrit levels were measured serially in each rat. Tissue oxygenation was estimated by skin bubble oxygen tension (PSBO<sub>2</sub>). Hematocrit, blood gases, and pH values were similar in all groups throughout the study. Means ± S.D. for DPG, P<sub>50</sub>, and PSBO<sub>2</sub> are shown above.

The fall in PSBO<sub>2</sub> for group I was significant. In contrast, PSBO<sub>2</sub> values for groups II and III increased and were significant for group III. The fall in PSBO<sub>2</sub> for group I occurred in association with significantly lower DPG and P<sub>50</sub> values, which remained decreased throughout the study. Enhanced tissue oxygenation in acidosis (group III) is probably the result of the Bohr effect on oxygen dissociation in vivo. Transfusion with DPG-depleted blood counters this effect on oxygen affinity and reduces tissue oxygenation. Extrapolated to humans, *these findings support the use of fresh rather than stored blood in acidotic states.*

\* \* \*

### The Toxic Metal Profile

Charles E. Willis, M.D., Cleveland, Ohio

Since the advent of the environmentalist, it has become more and more apparent that toxicity to heavy metals is not a rare disease condition. Acute poisonings are not as difficult to identify as chronic heavy metal toxicity with its insidious onset including vague neurologic symptoms. G.I. complaints, renal failure, dermatologic manifestations (alopecia and hyperkeratosis), and heart failure are all manifestations of heavy metal toxicity, which can easily be overlooked.

Because the symptoms are so varied and multiple, the physician frequently is unable to pinpoint

the exact toxic metal involved. We have felt that a screening procedure to rule out the important disease-causing metals would be in order. The most common are arsenic, cadmium, copper, zinc, lead, mercury, and iron. Others could be added to this list if a history revealed exposure. The advent of atomic absorption equipment of adequate sensitivity to detect microgram quantities of these elements has greatly facilitated the solution. It is possible today to screen, with automated chemical equipment, for many of these highly toxic substances on a routine basis at low cost.

The patient with multiple bizarre complaints, as in the anxiety neurotic, should have both urine and blood screened to rule out chronic heavy metal poisoning, even though the history fails to reveal exposure. This is especially true in children with neurologic problems.

This paper briefly reviews the clinical symptoms of heavy metal toxicity with several short case reports to demonstrate pertinent points.

\* \* \*

### Mechanism of Action of Antibiotics A Unifying Concept

Albert S. Klainer, M.D., F.A.C.P.,  
Morgantown, West Virginia

Scanning electron microscope studies were undertaken to investigate surface interactions between human phagocytes and bacteria of clinical importance. Treatment of bacteria with cell-wall-active antibiotics prior to exposure to phagocytes suggested that: (1) phagocytes attached to antibiotic-treated microorganisms more rapidly and in greater numbers than to untreated ones; (2) this difference became less apparent as the duration of exposure of bacteria to phagocytes increased; and (3) phagocytes exhibited a specific affinity for antibiotic-induced alterations, in many instances attachment occurring only at these sites. These studies suggest that an important mechanism of



action of antibiotics in vivo may be to alter surfaces of bacteria thus providing preferential sites for attachment by phagocytes and thereby enhancing the early host response to infecting microorganisms.

\* \* \*

### **Circulating Anti-Nuclear and Rheumatoid Factors in Selected United States Coal Miners**

H. L. Eckert, M.D., F.A.C.P.; N. Hahon, M.D.; M. L. Lippmann, M.D. (Associate); and W. K. C. Morgan, M.D., Morgantown, West Virginia

Serum specimens (sera) from 156 underground coal miners were examined for rheumatoid factor (RF) and anti-nuclear antibody (ANA). In addition, sera from 51 underground and surface miners with normal radiographs served as controls. A relationship between humoral auto-immune activity and the radiographic type of nodular opacity was sought. Sera were categorized according to the appearance of the miner's chest radiograph, namely, (1) complicated pneumoconiosis (progressive massive fibrosis (PMF); (2) simple pneumoconiosis; (3) normal; and (4) features suggestive of rheumatoid pneumoconiosis (Caplan's syndrome). Group 4 was divided into three sub-groups (4a, b, and c) viz, those with classical factors of Caplan's syndrome; those whose appearances were suggestive of this syndrome; and those in whom this syndrome was a possibility. Among the sera from group 4, only 9 percent showed the presence of rheumatoid factor (Singer and Plotz; titer  $\geq 1:160$ ), a rate which did not differ significantly from those with either simple or complicated pneumoconiosis. None of the sera from the miners with normal chest films (30 underground and 21 surface) showed RF or ANA. Age, years spent underground, and the geographic location of the mine did not appear to be related to the presence of RF. In contrast, ANA (titer  $\geq 1:10$ ) was present significantly more often in the sera of anthracite (55 percent) as opposed to bituminous miners (21 percent). In the case of anthracite miners with PMF, the figure was even higher (74 percent). The geographic region in which the bituminous mine is located appeared to influence the number of patients whose sera were positive for ANA. Thus, the sera of selected Central Pennsylvania miners were four times more likely to have ANA present than the sera of miners from Western Pennsylvania and West Virginia. Age and work history appeared to have no effect.

This study suggests that auto-immune activity may be related to the geographic location of the mine. There also seems to be a relationship between auto-immune activity and the prevalence of

CWP, viz, those regions with highest prevalence of CWP show the greatest number of miners with ANA in their sera. With the exception of sera drawn from subjects whose chest radiograph had features which were strongly suggestive of Caplan's syndrome, the type of nodular opacity (p, q, and r) appears to be unrelated to humoral auto-immune activity.

\* \* \*

### **Dissecting Aneurysm Associated with Severe Ischemia of the Leg**

J. Kramer, M.D., F.A.C.P., J. R. Young, M.D., and A. W. Humphries, M.D., Cleveland, Ohio

Early diagnosis and treatment of a dissecting aneurysm increases the survival rate. Because of its relative infrequency, even a classical presentation of dissecting aneurysm can be overlooked if the physician's index of suspicion is low. When acute ischemia of a leg is a prominent part of the clinical picture accompanying dissection, the patient is often wrongly diagnosed as having a myocardial infarction with subsequent thrombotic or embolic occlusion of his leg.

Fourteen of 53 patients with dissecting aneurysms seen at the Cleveland Clinic from 1955 to 1972 presented with acute occlusion of the iliac or femoral artery. The ischemic leg often dominated the clinical picture and obscured the correct diagnosis. The mechanism of occlusion appeared to be external compression of the arterial lumen by the dissection, followed at times by secondary thrombosis.

The presence of an ischemic leg is not necessarily an indication for surgical repair of the dissection itself. Surgery was planned for ten of these 14 patients: six died before surgery, two during surgery, one shortly after, and one patient is doing well four years postoperatively. Of four patients treated with a medical regimen, all survived with viable limbs.

\* \* \*

### **Systolic Time Intervals in Clinical and Investigative Medicine**

Paul M. Kohn, M.D., Cleveland, Ohio

The purpose of the presentation is to review briefly the methods and principles involved in assessing left ventricular function by means of a noninvasive technic using externally determined systolic time intervals (STI) and to demonstrate the practical value of this procedure in patient care as well as in clinical investigation. Significant correlation of the STI with cardiac output deter-

mined by externally monitoring the radioactivity over the precordium after the bolus injection of  $^{131}\text{I}$  human serum albumen was obtained in a group of 12 patients.

Clinically, determination of STI has proved useful in identifying symptomatic patients, particularly those with coronary artery disease or cardiomyopathy who had a significant degree of impairment of left ventricular function which was not apparent on routine physical examination and chest x-ray.

Determination of systolic time intervals was also very valuable in following patients with acute myocardial infarction, providing a guide for initiating digitalis therapy in individuals not in obvious pump failure, as well as for selecting those from whom digitalis subsequently could be withdrawn or those who would require maintenance therapy on a long-term basis. The beneficial effects of routine slow digitalization on myocardial contractility was demonstrated in a series of patients with impaired left ventricular function in whom the pre-ejection period and external isovolumic contraction time became significantly shortened and the left ventricular ejection time appropriately lengthened following long-term use of digitalis.

Clinical research employing STI included an investigation into the effect of thyroid hormone excess on myocardial contractility on ten patients with documented hyperthyroidism. STI were determined before and after radioactive iodine therapy and significant shortening of the various components of ventricular systole was found to characterize the hyperthyroid patients. After RAI therapy had produced an euthyroid or hypothyroid state, reassessment revealed lengthening of the PEP and EICT to normal or abnormally increased intervals.

A study of left ventricular function in patients with end-stage renal disease who were either on dialysis or had kidney transplants demonstrated marked impairment in all cases. The transplantation group manifested less severe involvement, suggesting the possibility of a renal toxin which presumably depresses myocardial contractility.

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#### Cardiac Venous Blood Flow Response to Atrial Pacing in Normal Patients and Those with Coronary Artery Disease

Robert C. Bahler, M.D., F.A.C.P., Cathel A. MacLeod, M.B., F.R.A.C.P., and Brian Davies, M.D., M.R.C.P., Cleveland, Ohio

Ability to increase great cardiac venous blood flow (GCVBF) was quantitated in six normal and 28 angina pectoris subjects who underwent diagnostic coronary angiography. GCVBF was mea-

sured by the thermodilution method of Ganz, at rest and during the atrial pacing test. Pacing was started at 100 beats per minute and increased 10 beats every two minutes until angina pectoris, a heart rate of 150 beats per minute, or second degree A-V block appeared. Hemodynamic observations were obtained at every other rate increment and with the onset of angina pectoris. A comparison of the hemodynamic parameters at rest and at the maximum-paced heart rate revealed that in 23 patients who developed angina during pacing (group I), the systolic pressure-heart rate product ( $\text{SP} \times \text{HR}$ ) increased  $61 \pm 4.2$  SEM percent, tension-time index (TTI) increased  $36 \pm 3.4$  percent, and GCVBF rose  $50 \pm 7.1$  percent. In five patients who did not develop angina with pacing (group II),  $\text{SP} \times \text{HR}$  increased  $84 \pm 13.0$  percent, TTI  $33 \pm 10.0$  percent, and GCVBF  $83 \pm 14.0$  percent. In normal subjects (group III), the  $\text{SP} \times \text{HR}$  increased  $76 \pm 13.9$  percent, TTI  $36 \pm 5.3$  percent, and GCVBF  $102 \pm 9.9$  percent. The maximum-paced heart rate was  $119 \pm 3$  in group I versus  $148 \pm 2$  in group II, and  $134 \pm 4$  in group III. A significant increase in systolic pressure during pacing occurred only in group I. There was a significantly lesser rise in GCVBF in group I compared to group III ( $p = .001$ ), despite similar increases in both TTI and  $\text{SP} \times \text{HR}$ . The greatest limitations in ability to increase GCVBF were evident in patients with severe extensive coronary disease, yet the overall correlation of the visualized extent of disease and the degree of GCVBF limitation was not significant ( $r = .3$ ,  $p = .15$ ). However, there was significant positive correlation ( $r = .62$ ,  $p = .01$ ) between a patient's ability to increase GCVBF and his physical work capacity, as assessed by a multistage progressive bicycle ergometer test.

*Measurement of GCVBF, during the stress of atrial pacing, has provided a simple approach to the quantitation of regional coronary blood flow.*

\* \* \*

#### A Study of the Immunologic Aspects of Chronic Berylliosis

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The pathogenesis of lung disease in chronic berylliosis is poorly understood, however, immunologic mechanisms have been suggested to play an important role in this disease. The previous immunologic evidence has been largely indirect, from studies on skin tests with beryllium salts. We have investigated the role of cellular immune mechanisms in this disease by studying the blast transformation of lymphocytes of these patients (35) in



the presence of beryllium sulfate ( $\text{BeSO}_4$ ) in tissue culture. The control groups included beryllium industry workers without disease (30), normal, healthy individuals (22), and patients with other lung diseases (12). The degree of blast transformation was graded (1+ to 4+) on the basis of morphologic counting of blast cells and in some cases also by the uptake of tritiated thymidine. Circulating serum immunoglobulin levels were also measured. Of the 35 patients with chronic berylliosis, 18 demonstrated a blast transformation of 4+, three showed 3+, four showed 1+, and ten were negative. There was also a good correlation between the severity of the clinical disease and the degree of blast transformation. The incidence of positive results in the control groups was extremely low. Serum IgA level was significantly elevated in 17 patients with berylliosis. At the time of testing, all patients with berylliosis were being treated with varying doses of prednisone, and since steroids usually inhibit the blast transformation response, our finding of a positive reaction in 71 percent of the patients (25 out of 35) lends strong evidence for the role of cellular-immune mechanisms in this disease.

\* \* \*

### Mechanism of Airflow Obstruction in Coal Miners

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Twenty-five working, bituminous coal miners with radiographic evidence of category 2/1 or greater simple pneumoconiosis and six non-miner controls underwent studies of lung mechanics. No appreciable differences existed between the miners and controls with regard to age, height, total lung capacity, residual volume, or airway resistance. Miners had a slightly lower  $\text{FEV}_1/\text{FVC}$  ratio than the controls (mean values 76 percent vs 81 percent). Analysis of pressure, flow, and volume relationships demonstrated that miners as a group achieved lower maximal expiratory flows than the controls at comparable lung volumes and pressures. Two mechanisms appeared to account for these findings. Seventeen of the miners demonstrated reduction of dynamic compliance at faster respiratory rates, a phenomenon that may indicate obstruction in small peripheral airways. In the remaining eight miners, reduction of maximal expiratory flow appeared to result from a loss of lung recoil pressure. The latter appeared to be a consequence of focal emphysema, while the fall in dynamic compliance at faster respiratory rates in

the miners with normal lung recoil pressures is probably a result of bronchiolitis.

\* \* \*

### Uric Acid Nephrolithiasis in Familial Fanconi Syndrome

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Fanconi syndrome, characterized by glycosuria, phosphaturia, aminoaciduria, and uricosuria, and often hypophosphatemia and hypouricemia is due to a proximal renal tubular defect. In addition to a genetic form, many acquired cases may result from heavy metals (lead, cadmium, copper in Wilson's Disease) and from amphotericin B, outdated tetracycline, and occasionally paraproteinemias. In the complete form, renal tubular acidosis with acidemia and persistent alkaline urine is usually present. Nephrocalcinosis and nephrolithiasis may occur with calcium phosphate or oxalate being the chief constituents, owing to a defect in urinary acidification with resultant persistent alkaline urine. Despite excessive uricosuria, uric acid calculi have not been described.

We report here a patient who had recurrent radiolucent renal calculi, beginning at 17 years of age. At age 48, he developed renal colic with non-opaque calculus and was found to have hypouricemia (1 to 2 mg per 100 ml). In the subsequent two years, two more episodes of renal calculi accompanied by serum uric acid of 1 to 2 mg per 100 ml occurred. Xanthinuria was excluded. He excreted large amounts of uric acid (highest value 1600 mg/24 hr). Serum uric acid was persistently low, varying between 0.9 and 1.3 mg per 100 ml. Uric acid clearance was extremely high (35-46 ml/min). Creatinine clearance was normal in repeated measurements (108-125 ml/min). Serum and urine oxypurines (xanthine and hypoxanthine) were not increased. Hypophosphatemia, increased phosphate clearance, and glycosuria were consistently present. Urinary alpha-amino nitrogen was slightly increased and chromatography showed a slight increase in number and in concentration of amino acids. There was no evidence of a defect in urinary acidification. Contrariwise, urine was persistently acid, varying between pH 5.0 to 5.5 with a simultaneous arterial pH of 7.34.

A brother of the propositus developed renal colic at age 51 and had a second calculus removed at age 53. He and another asymptomatic brother, age 62, were also found to have hypouricemia 0.8 to 1.0 mg per 100 ml, glycosuria in the presence of normal plasma glucose, and phosphaturia. This is the first report of uric acid calculi in the Fanconi syndrome, the probable cause being persistent



acid urine accompanying extremely high excretion of uric acid.

\* \* \*

### Progress Report of an Office Practice Audit Process in West Virginia

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For the practicing physician, postgraduate medical education means a continuous readjustment of behavior on the part of that physician as he applies problem solving and treatment skills to those committed to his charge. The medical audit is a time-honored process used in the retrospective analysis of practice. To date, however, it has been restricted to the hospital. More recently, the American Society of Internal Medicine has recognized the need to evaluate office practice for the purposes of education. In West Virginia a similar activity has been operating for the past year and a half under the auspices of the West Virginia State Medical Association and the Regional Medical Program. In this experiment, 55 physicians were asked to participate, 36 of whom have accepted. There has been 100 percent acceptance by those physicians age 44 years and under, and 70 percent acceptance by those age 64 years and under. The acceptance by West Virginia internists has been seven of 13 requested. In contrast, six of

the six surgeons and six of the seven obstetrics and gynecology specialists are participating. In the other nonsurgical specialties, nine of the 16 general practitioners and two of three pediatricians have agreed to participate.

The most distinguishing features of the West Virginia self-audit service are that it is voluntary and that it functions in the framework of subjects and criteria selected by the physician himself, rather than asking him to adopt ones developed by others. Furthermore, the participating physician submits his criteria as well as the results of the chart audits to two peers of his choice. In the field of internal medicine, diabetes, hypertension, and coronary heart disease have been popular subjects chosen. The results of the audit of these diseases by the individuals have been, on the whole, very good, indicating a high level of quality practice by the participants.

Several unexpected modifications of the standard approach to the audit process as it applies to the office audits were learned. Attitudes and behavior trends are of interest and will be presented. The potential for continual education, recertification, as well as improvement of the actual day-to-day management of office practice are broad in the application of this process.

Other issues in reference to the peer review process and its relation to the teaching centers, as well as the development of the medical records technician or the health care accountant, were discussed.

## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

A 7-year-old boy is brought to your office because of persistent hoarseness of two years' duration.

His pharynx is not congested. He has a husky,

low-pitched voice. His family history is significant in that he has four siblings and he frequently shouts and screams at them.

What is his most likely diagnosis and how can it be made?

\*Dr. Miglets, Columbus, is Assistant Professor of Otolaryngology, The Ohio State University College of Medicine.  
Submitted March 28, 1972.

*(See p. 214 of this issue for further information and discussion.)*

# Technics, Problems, and Gains In Interviewing Next of Kin

## An Environmental Study

ANN E. DE GROOT, M.C.P., and RALPH E. YODAIKEN, M.D.

**I**NTerviewing NEXT OF KIN of patients undergoing autopsy in an environmental study was found to be an important supplement to information supplied on hospital charts and made autopsy findings more meaningful. Hospital chart information is often incomplete and may be biased. Associations may be missed because of the manner in which information is obtained. Often relatives are in a better position to see the total picture of the patient's illness and provide additional relevant information that may increase our understanding of the pathogenesis of disease. Long-term environmental exposures, ones which do not necessarily lead to acute clinical disease, usually play a minor part in a medical history. Yet such exposures in the home, at work, or in the general geographic environment may contribute significantly to the contracted disease.

### Previous Research Using Next-of-Kin Interviews

Interviewing next of kin is rarely chosen when additional information is required on a deceased patient. Other investigators have found that obtaining detailed information from next of kin is difficult. Cases concerning death caused by, or complicated by alcoholism, drug abuse, or homicide have to be avoided because of the difficulty in assessing the accuracy of the information. Sources of information should be restricted to the

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spouse or any other close relative or friend who has lived with the deceased for a known period of time prior to death. Beadenkopf and Marks<sup>1</sup> suggested that six months should be allowed to elapse between the death of the patient and the initial contact of next of kin. They attributed their low refusal rate (2 percent) to the long waiting period. However, according to oral communications from Lewis H. Kuller, M.D., in January 1972, and Elisabeth Kübler-Ross, in December 1971, they used shorter time intervals. In each of these as well as in our study, no difficulty was encountered in obtaining the cooperation of the next of kin. On the contrary, there are strong indicators that such contacts are frequently needed for psychological reasons and that such interviews should be conducted by sensitive (but not necessarily psychiatrically trained) hospital personnel as a service to the survivors themselves.<sup>2</sup> This conceptualization is reinforced by an examination of the psychology of the mourning process,<sup>3,4</sup> the death denial in each of us,<sup>5,6</sup> and recognition of the concept put forward by Kübler-Ross that such

This study was carried out in the Department of Pathology, Cincinnati General Hospital and was supported by US Department of Health, Education, and Welfare contract CPE-R-70-0041 obtained through the Bureau of Occupational Safety and Health.

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interviews are actually helpful and needed by the survivors.

Materials and Methods

The primary object of this study was to supply the Federal Bureau of Occupational Safety and Health (BOSH) with 100 lungs which could be used as controls against the lungs of miners with "black lung disease." Second, it was to serve as a pilot study on information linking lung conditions at death with environmental conditions (which included the diet) during life.\*

1. *Subjects in the Study.* — The lung samples used came from autopsies performed at Cincinnati General Hospital, Cincinnati, Ohio (pathology department), and the subjects were determined by the needs of the study.

2. *Procedures Followed.* — Once a case qualified for inclusion in the study, complete information was extracted from the hospital chart, summarized, and carefully reviewed before the interview with next of kin, which took place four to five weeks after the death occurred. Within a few days of the death of the patient, the attending physician (if one was named in the chart) was contacted and his cooperation sought.

3. *The Initial Contact and the Interview.* — Wherever possible, initial contact with next of kin was made by telephone. When phone numbers were unlisted or not in service, visits were made to the home; if no one was at home, a certified letter was sent to the address. During the initial contact the purpose of the study was explained in simple and brief terms. The looseness of this original contact was considered essential to establishing a workable rapport between the interviewer and the respondent. It was preferred that the interview be conducted in the respondent's home (or at place of work) since this provided person-to-person contact. A telephone interview was only taken when the respondent appeared to avoid setting a time or place or personally suggested the use of the telephone. All hospital telephone operators were informed of the project and this turned out to be a wise precaution, since some potential respondents telephoned the hospital to validate the interviewer's identity and research goals.

4. *The Interview.* — With few exceptions (see Results), the interviewer kept her own identity and did not use any specific form of dress, such as a white coat, to draw attention to her association with the hospital. Although a standard ques-

tionnaire was used in each case, the interview was as unstructured and informal as possible.

Results

Significantly the physician who had been in attendance had specific and important guidance to offer regarding the interview. In one case only, the physician chose to fill out the questionnaire himself. In addition to the importance of this guidance, it was found that when making the initial telephone contact, the next of kin were reassured on hearing that their doctor had been contacted. Frequently, the caller was immediately questioned about items which had been left at the hospital or asked how to deal with complicated medical payment forms, or when and how to obtain autopsy information and/or death certificates. Where possible this information was supplied. In every instance, the assistance was appreciated and it opened the door to what otherwise may have been a strained conversation. The mode of initial contact is given in Table 1.

The level of anxiety expressed over the telephone regarding the setting of a time and place

TABLE 1. Nature of Initial Contact with Respondent

| Method of Contact                  | Respondents With Telephones (%) | Respondents With Unlisted Telephones (%) | Respondents Without Telephones (%) | Total (%) |
|------------------------------------|---------------------------------|--|------------------------------------|-----------|
| Respondent's phone                 | 91                              | —  | —                                  | 91        |
| Via operator if telephone unlisted | —                               | 3  | —                                  | 3         |
| Relative or friend's telephone     | —                               | —  | 1                                  | 1         |
| Visit to respondent                | —                               | 2  | 1                                  | 3         |
| Mail                               | 1                               | 1  | —                                  | 2         |
| Total % of 100 cases               | 92                              | 6  | 2                                  | 100       |

in three specific instances appeared quite clearly to be the beginning of a refusal for the interview. In these instances, the suggestion to conduct the interview by telephone right then seemed to release the respondent from whatever anxieties were at work and the questions were answered. Consequently, no potential interviews were lost. The refusal rate was zero (Table 2). It was found that

TABLE 2. Nature of Contact with Respondent During Interview

|                                     | Number |
|-------------------------------------|--------|
| Person-to-person, respondent's home | 63     |
| Person-to-person, elsewhere         | 8      |
| Via telephone, Respondent's choice  | 23     |
| Interviewer's choice                | 3      |
| Mail                                | 3      |
| Total                               | 100    |

\*The BOSH will publish papers concerning the findings on miners and the methods of homogenizing, freeze drying, and analyzing lung tissue for trace metals. The pathological details of this study will be published separately and at a later date.



the six respondents who expressed a reluctance to be interviewed later called the hospital to check our identity and only then approved the interview.

During both the initial contact and the subsequent interview, the respondents were receptive in all but eight cases. Many interviews ended in looking through family picture albums and others through family Bible inscriptions. One concluded with the proud showing of a carefully nursed and surprisingly active 107-year-old grandmother who was awakened in her chair at the back of the room to shake the interviewer's hand. Another ended with the reading of a phrenological analysis which had been done on the patient under investigation at the age of 1 year and involved predictions of state of health.

Some interviews were difficult. One was almost denied when it was discovered that the reason for noncooperation was a recent publication by the Black Muslims attacking all health professionals as being racist for not carrying out enough research in the area of sickle cell anemia. When the name and telephone number of a local group organized to improve the situation was given, an enthusiastic interview was immediately granted. Interviews with persons seemingly still deep in the early phases of the mourning process (six), with others who were unable to stay with a single train of thought (three), one of whom was thought to be on a hard drug at the time of the interview, and with persons who did not know the patient well (three) were difficult in obvious ways. In such cases, second interviews concerning the same patient were successfully carried out with other next of kin, neighbors, or friends (Table 3).

Medical Information Given  
to Respondents

Most conversations with respondents eventually found their way to questions regarding the nature of the patient's illness. The Cincinnati General Hospital has a system through which next of kin may obtain free official reports of autopsy findings written in layman's terms. When necessary, the respondent was directed to the relevant telephone number. Similarly, when medical or medically related questions were raised the respondent was directed to a physician or clinic doctor. It was found that, in these situations, it

was useful for the interviewer to be nonmedical. In fact, initially a white coat, which was worn in an attempt to accentuate the tie with the hospital complex, was quickly discarded when it was found that this dress interfered with the development of the type of rapport sought. In some instances, the interviewer (de Groot) was accompanied by the physician (Yodaiken) but, in each case, these interviews too quickly moved to specific medical questions so that the physician's attendance was discontinued. Without the doctor, the questions took on a relaxed tone.

Verification of Probable Accuracy  
of Information

In order to rate the likelihood of obtaining trustworthy answers, two different rating scales were applied to each interview.

First, the closeness of the respondent to the patient was rated by the use of the letters "A", "B", and "C".

"A" referred to a respondent who had lived with the patient during the last year of the patient's life and was very familiar with his or her personal habits, behavior, residences, and jobs. This could be a spouse, family member, or a roommate. A spouse who had left the patient's home not more than a year previously was also considered an "A" respondent. There were 57 "A" respondents in this study (Table 4).

"B" referred to a respondent who had lived with the patient for varying amounts of time; for example, a niece who had lived in the household during different but prolonged periods of her life but who was not necessarily an integral part of the household. A cousin raised with the patient, who had helped to care for him or her by bringing food daily during late years, was also considered a "B" (Table 4).

"C" referred to a respondent who had not lived with the patient long enough to fall into either of the above categories but who had known him or her intimately, eg, a more distant relative, a close friend, or a neighbor (Table 4).

After the interview had been completed, the interview rapport was rated on a scale from one to five. Number 1 signified a friendly, relaxed interview and number 5 an unfriendly, hostile interview. There were 80 of the 1-type interviews and only one 5-type interview (Table 5).

With these guidelines, the discrepancies between the information obtained from the hospital chart and that from the interview was carefully noted (Table 6).

Finally, the autopsy reports also were reviewed and compared to the medical histories and diagnoses. A list of items obtained by interview and not appearing on the hospital chart or autopsy

TABLE 3. Relationship of Respondent to Patient

|  | Number |
|--|--------|
| Spouse   | 27     |
| Immediate family other than spouse<br>(parent, sibling, offspring) | 49     |
| Relative other than immediate family                               | 19     |
| Friend, neighbor   | 5      |
| Total  | 100    |

TABLE 4. Respondent Type, Familiarity with Patient Behavior and Health

| Respondent Type                     | Number |
|-------------------------------------|--------|
| A                                   | 57     |
| B                                   | 34     |
| C                                   | 9      |
| Total                               | 100    |
| A Lived with patient                |        |
| B Lived with patient intermittently |        |
| C Intimate relative or friend       |        |

protocol is given in Table 7. This table indicates that a high percentage of information not present in hospital records can be obtained successfully from next of kin.

Discussion

It should be recognized that the patients used in this study do not comprise a statistical random sample of any universe to which findings can be validly generalized. This fact applies to this circumstance not only because of the manner in which the patients included were chosen from among the larger group of autopsied patients, but also because of the fact that those patients generally do not comprise a representative sample of the universe of diseases (neither in incidence or prevalence), of demographic profiles of types of persons, or of a combination thereof.<sup>7-13</sup> Nevertheless, considerable gains were made from the interviews.

*Summary of Gains:* The accuracy of information obtained by interviewing itself is a topic of many publications.<sup>14-18</sup> Quite apart from the inevitable contradictions or apparent contradiction between some answers obtained by interview and the hospital charts (and not belittling the problem of assessing the information's validity for use in this or any study of man), it is important to recognize the overriding value of the new information. The typical medical history does not include

TABLE 5. Tone of Interview re Cooperation, Friendliness

| Tone of Interview        | Number |
|--------------------------|--------|
| 1                        | 80     |
| 2                        | 12     |
| 3                        | 4      |
| 4                        | 3      |
| 5                        | 1      |
| Total                    | 100    |
| 1 Friendly and relaxed   |        |
| 2 Formal but cooperative |        |
| 3 Guarded                |        |
| 4 Reluctant              |        |
| 5 Hostile                |        |

many items likely to have played a significant role in the health of the patient. These have been broken down into the general categories of home environment, general environment, work environment and patient's and family's medical histories. It was found, for example, that almost all households use iron skillets for frying and this is a potential source of iron in the diet (Table 7).

It is not possible to correlate the extent of the pollution of the environment to the particulate and metal content of the patients' lungs owing to a dearth of pollution-monitoring systems in the metropolitan Cincinnati area, but it is hoped that estimations ultimately will be made. The relationship between the environment and the content of the lung tissue can only be assessed if such factors as the amount of time spent walking, bus riding, and the habit of leaving house windows open is known. The interviews also expose hidden pollution factors such as sprays, dust from carpentry, and paint. With this baseline information, it will be possible to correlate pollution hazards with tissue absorption levels in future studies.

An indication of exposures to fumes, vapors, and particulate matter at work was also ascertained by determining the job history. Work in perfumeries, foundries, carton-making production

TABLE 6. Incidence of Additional Information or Discrepancies Between Interview Information and Hospital Chart

| Source of Information Listed by Respondent Type |                                   |      |        |      |       |      |             |                  |
|---|-----------------------------------|------|--------|------|-------|------|-------------|------------------|
| A (57)  |                                   |      | B (34) |      | C (9) |      | Total (100) |                  |
| Information Type                                | Cases                             | %    | Cases  | %    | Cases | %    | Cases       | Total Interviews |
| Alcohol consumption                             | 34                                | 59.6 | 21     | 61.8 | 7     | 77.8 | 62          | 62               |
| Tobacco use                                     | 35                                | 61.4 | 27     | 79.4 | 7     | 77.8 | 69          | 69               |
| Patient's medical history                       | 14                                | 24.6 | 12     | 35.3 | 2     | 22.2 | 28          | 28               |
| Family's medical history                        | 36                                | 63.2 | 25     | 73.6 | 6     | 66.7 | 67          | 67               |
|   |                                   |      |        |      |       |      |             |                  |
| A   | Lived with patient                |      |        |      |       |      |             |                  |
| B   | Lived with patient intermittently |      |        |      |       |      |             |                  |
| C   | Intimate relative or friend       |      |        |      |       |      |             |                  |

These represent only a sample of information types which could be included. Some others are given in Table 7.

TABLE 7. Information Obtained by Interview Which Did Not Appear in Hospital Charts or Autopsy Protocols

| Type   | Successfully<br>Obtained by<br>Interview for<br>100 Cases<br>(%) | Information<br>Not Present on<br>Hospital Charts or<br>Autopsy Protocols of<br>100 Cases<br>(%) |
|--|--|---|
| Home environment exposures:                            |  |   |
| Heat source (coal, oil, gas, etc.)                     | 63   | 63  |
| Ventilation practices & devices                        | 74   | 74  |
| Humidity adaptations                                   | 79   | 79  |
| Cooking utensils used                                  | 72   | 72  |
| Work environment exposures:                            |  |   |
| Complete work history                                  | 86   | 82  |
| Partial work history                                   | 14   | 14  |
| Other environmental exposures:                         |  |   |
| Hobbies (carpentry, gardening, sports, painting, etc.) | 69   | 68  |
| Residences   |  |   |
| Complete history                                       | 84   | 84  |
| Partial history  | 15   | 15  |
| Patient's medical history                              | 85   | 28  |
| Family's medical history                               | 83   | 67  |

These represent only sample of information types which could be included. Some others given in Table 6. "Medical histories" are in both tables for comparison.

lines, rag businesses, construction, demolition, bakeries, etc, each has a special type of exposure problem. Each one of these may be related to the ultimate lung pathology and this information is expected to be the most important pay-off of the interviews.

The interviews with next of kin also uncovered the family's medical history in great detail. Such information was often more extensive than that supplied by the patient in the hospital. Few people are fully aware of relatives' illnesses or causes of death. Familial-heredity questions asked of the distressed patient in the hospital are often incomplete. During the interviews, however, respondents who could only recall vague impressions of family diseases made phone calls to other relatives and, in this way, a considerable amount of information was accrued in 67 percent of the interviews.

Information concerning the patient's personal lifetime medical history was expanded in 28 percent of the cases.

As a result of the study, we feel that we are in a position to outline certain guidelines for future interviews and, since such guidelines are difficult to obtain from the literature, we conclude by making a few suggestions:

1. The initial contact with next of kin should be made within three to four weeks after the death of the patient, and the interview itself should take place approximately one month after death of the patient.

2. The interviewer must be familiar with the disease and cause of death of the patient. A prior review of the hospital chart is essential to the

interview, but at the same time, regardless of the interviewer's status, no medical information should be supplied during the interview.

3. The interviewer must be relaxed both during the original telephone contact and during the interview. While a structured questionnaire should be used as the basis for discussion in all cases in order to assure that the information obtained in each case is similar, the questions should not be formally read from a question paper. It is helpful if the interviewer adopts an informal approach while continuing to follow a standard questionnaire format for each interview. The interviewer should be familiar with and sensitive to the stresses of mourning.

4. The interviewer should not be a physician, nor should he or she be formally dressed to indicate any association with the hospital complex.

5. Hospital authorities and telephone operators in particular should be aware of the investigation.

6. It is essential that the interviewer be equipped with knowledge of hospital procedures — places where lost items are kept, social agencies such as insurance companies, compensation boards, and health agencies. He or she should also be well aware of current racial issues (blood bank problems).

With these guidelines, a sensitive interviewer can obtain valuable information from next of kin and our zero-percent refusal rate is gratifying. It is also gratifying to note that it is possible to add to hospital charts a considerable amount of information that is normally concealed because of the



nature of the relationship between the hospital patient under stress and his or her physician.

### Summary

Interviews were conducted with the relatives or close friends of 100 patients upon whom autopsy had been done and whose lungs were acquired for an environmental study. The interviews were carried out approximately one month after the death of the patient. In nearly all cases the respondents were receptive, and consequently it was possible to add a considerable amount of information, particularly relating to the environment, work conditions, places of residence, and family medical history. The respondents were graded according to their relationship to the patient and according to their response to the interview. In conclusion, guidelines are suggested for similar studies involving contacts with next of kin and close friends.

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**MIGRATION OF PHYSICIANS.** — The physician supply in the United States now includes over 63,000 foreign medical graduates. They comprise one fifth of the active physicians, about one third of hospital interns and residents, and a similar proportion of newly licensed physicians.

In the past ten years the number of foreign medical graduates entering the country has increased at a faster rate than domestic production. Developing countries, particularly in the Far East, have become the principal sources of supply. Many exchange visitor physicians may now remain permanently in the United States.

Basic training received in many countries is not equivalent to that acquired in American schools, nor is the graduate training offered in this country appropriate to the needs of the majority of foreign medical graduates. Although "push factors" condition many foreign graduates to leave their own countries, sound policy dictates that we discontinue the active recruitment of such physicians to meet domestic needs, particularly for hospital services. — Thomas D. Dublin, M.D., Dr.P.H. Bethesda, Md.: *The New England Journal of Medicine*, 286:870-877, April 20, 1972.



# WHEN **FLU** HITS AND HURTS

HERE

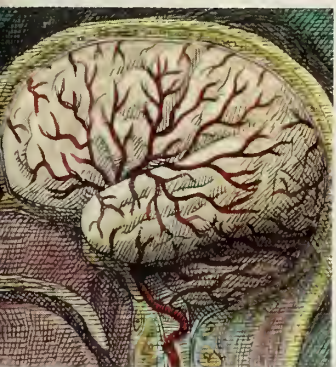
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and joints



Wherever it hurts, Empirin  
Compound with Codeine usually  
provides the symptomatic  
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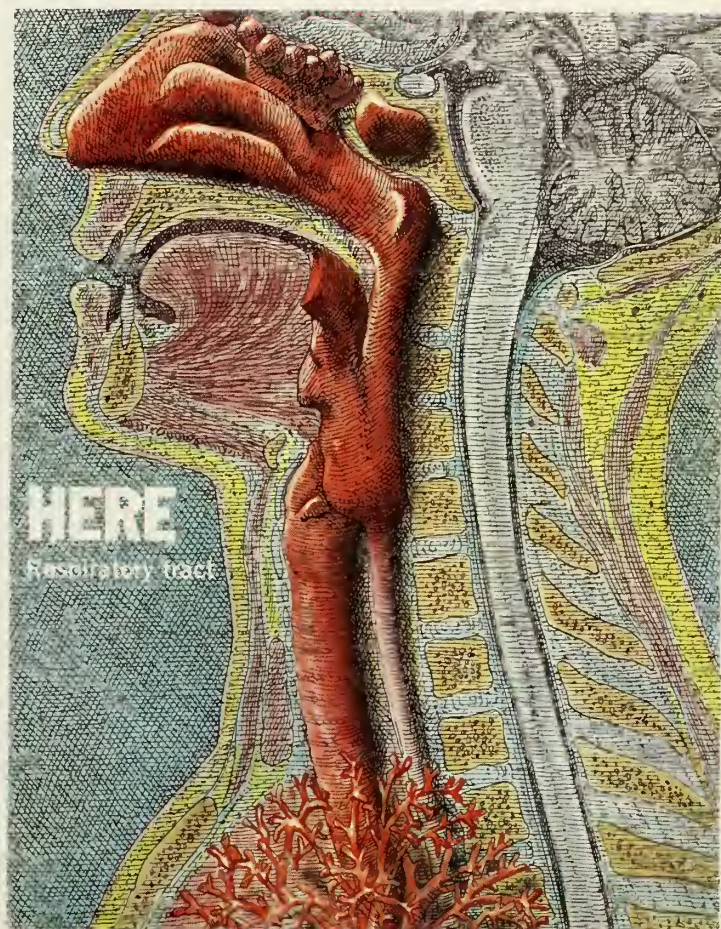


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**IMPORTANT INFORMATION:** This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdose or individual hypersensitivity, reactions similar to those after meperidine or morphine overdose may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

**Indications:** Lomotil is effective as adjunctive therapy in the management of diarrhea.

**Contraindications:** In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

**Warnings:** Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.


**Usage in pregnancy:** Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the

breast milk of nursing mothers.

**Precautions:** Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

**Adverse reactions:** Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy.





**Many  
things  
can cause  
diarrhea.**

**LOMOTIL<sup>®</sup>  
will almost  
surely stop it.**

The causes of diarrhea are as varied as man's complaints and indiscretions. Because the causes of diarrhea can be obscure and because uncontrolled diarrhea can present serious problems, it is important to know a drug that will usually stop diarrhea promptly. For many physicians, the antidiarrheal drug of choice is Lomotil. It provides almost certain control of diarrhea.

It is also useful in controlling the intestinal transit time of patients with ileostomies and colostomies and the diarrhea occurring after gastric surgery.

Serious side effects are infrequent with Lomotil. It should be used with caution in young children, however, because of their variability in response. Use of Lomotil in children under two years of age is contraindicated.

**For the almost certain  
control of diarrhea,**

**LOMOTIL<sup>®</sup>**  
**TABLETS/LIQUID**

Each tablet and each 5 ml. of liquid contain:  
Diphenoxylate hydrochloride . . . . . 2.5 mg.  
(Warning: may be habit forming)  
Atropine sulfate . . . . . 0.025 mg.



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exia, restlessness, euphoria, pruritus, angioneu-  
edema, giant urticaria and paralytic ileus.

**Contraindications:** Lomotil is contraindi-  
cated in children less than 2 years old. Use only  
Lomotil liquid for children 2 to 12 years old. For  
children 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years,  
(2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5  
times daily; adults, two tablets (5 mg.) t.i.d. to two  
tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10  
mg.) q.i.d. Maintenance dosage may be as  
low as one fourth of the initial dosage. Make down-  
dosage adjustment as soon as initial symptoms  
are controlled.

**Warnings:** Keep the medication out of the reach  
of children since accidental overdosage may cause  
coma, even fatal, respiratory depression. Signs of  
overdosage include flushing, lethargy or coma, hypo-  
reflexes, nystagmus, pinpoint pupils, tachy-  
cardia and respiratory depression which may occur

12 to 30 hours after overdose. Evacuate stomach by  
lavage, establish a patent airway and, when neces-  
sary, assist respiration mechanically. Use a narcotic  
antagonist in severe respiratory depression. Obser-  
vation should extend over at least 48 hours.

**Dosage forms:** Tablets, 2.5 mg. of diphenoxylate  
HCl with 0.025 mg. of atropine sulfate. *Liquid*, 2.5  
mg. of diphenoxylate HCl and 0.025 mg. of atropine  
sulfate per 5 ml. A plastic dropper calibrated in in-  
crements of 1/2 ml. (total capacity, 2 ml.) accom-  
panies each 2-oz. bottle of Lomotil liquid.

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panies each 2-oz. bottle of Lomotil liquid.

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Before prescribing, see complete prescribing information in SK&F literature or PDR.

**Indications:** Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

**Contraindications:** Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

**Warnings:** Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects with alcohol and other CNS depressants.

**Usage in Pregnancy:** In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

**Effect on PBI Determination and I<sup>131</sup> Uptake:** Isopropamide iodide may alter PBI test results and will suppress I<sup>131</sup> uptake. Substitute thyroid tests unaffected by exogenous iodides.

**Precautions:** Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

**Adverse Reactions:** Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

**Supplied:** Bottles of 50 capsules.

SK&F Smith Kline & French Laboratories

# Pseudotumor of the Colon

OUEN PONGDEE, M.D., AND EMIL GUTMAN, M.D.

A VARIETY OF CONDITIONS may simulate carcinoma of the colon. Among the extrinsic causes are inflammatory diseases and adhesions around the wall of the large intestine. These may result in constriction and, on barium enema examination, may give the appearance of intramural and intraluminal masses resembling colonic tumors.<sup>1,2</sup> Awareness of this is important to avoid unnecessary surgery. We recently encountered a patient with colonic obstruction which appeared identical to annular carcinoma on barium enema examination. Surgery was performed and the lesion was found to be a localized abscess with adhesions causing constriction.

## Case Report

A 46-year-old white man was admitted to the Veterans Administration Hospital, Dayton, Ohio, on November 29, 1971, with a history of colicky and cramping abdominal pain on and off for one month. The pain became more severe and was associated with diarrhea five to six times a day and emesis for about a week prior to admission. The patient lost about eight pounds during the month preceding admission. He had had a partial gastrectomy for gastric ulcer in 1959, a laminectomy for herniated disc in 1967, and hemorrhoidectomy in 1969.

On admission, he appeared in no acute distress. Pulse rate was 96 beats per minute, blood pressure 118/84 mm Hg, and temperature 37 C (98.6 F). The abdomen was distended but soft with no tenderness. Bowel sounds were hyperactive. Rectal examination showed no abnormali-

## The Authors

- Dr. Pongdee, Dayton, is Resident in Radiology, Veterans Administration Center.
- Dr. Gutman, Dayton, is Chief, Radiology Service, Veterans Administration Center; and Clinical Assistant Professor of Radiology, The Ohio State University College of Medicine, Columbus.

ties. Laboratory studies were within normal limits except for leukocytosis of 13,000 per cu mm with normal differential.

Initial plain films of the abdomen showed dilation of the small bowel and transverse colon with minimal gas in the left side of the colon. Multiple air-fluid levels were seen on the erect and decubitus views. Emergency barium enema examination disclosed a concentric, narrowed segment in the splenic flexure with marked narrowing of the lumen and some shelving of the margins, giving the appearance of a napkin-ring type of defect (Fig. 1). A pressure spot film (Fig. 2) showed the same findings. The colon proximal to the narrowed segment was dilated. The lesion was again seen on the postevacuation film (Fig. 3). The mucosal pattern was not satisfactorily demonstrated. The findings were consistent with an annular carcinoma of the splenic flexure.

Surgery was performed on the same day. Moderate adhesions were encountered over the transverse colon and the splenic flexure. Findings during operation revealed a firm constricted area and a small pocket of pus at the splenic flexure which was thought to be a tumor. Resection of the splenic flexure and end-to-end anastomosis were accomplished. A growth of alpha-enterococci

Reprint requests to Veterans Administration Center, 4100 West Third Street, Dayton, Ohio 45428 (Dr. Gutman).

Submitted August 23, 1972.



was found on pus culture. The postoperative course was good except for a minor complication of incisional wound infection.

Pathologic examination of the resected colon showed irregular serosal thickening with inward contracture resulting in narrowing of the lumen. The mucosal surface presented normal rugae with no evidence of tumor mass or ulceration. Microscopic examination showed focal, mild polymorphonuclear leukocytic infiltration and marked fibrous thickening of the serosa. The mucosa showed no atypical change.

### Discussion

Inflammatory processes and adhesions are among the numerous causes of deformities of the colon.<sup>3</sup> Intestinal obstruction due to adhesions and fibrous bands are known to be common. The radiographic appearance usually shows a short area of constriction with a smooth and tapered edge. A napkin-ring defect may be found in endometriosis and is sometimes difficult to distinguish from that due to carcinoma.<sup>4</sup> Spasm of the colon may produce obstruction and many of these areas simulate malignancy.<sup>5</sup> A satisfactory demonstration of intact mucosa is the most important clue to differentiate these from carcinoma.

In this reported case, the development of the adhesion was probably partly due to the previous abdominal surgery and partly from the inflammatory process, but the pathogenesis of the sup-



FIG. 1. Splenic flexure filled with contrast material.

purative inflammation resulting in a small abscess formation is not entirely clear. In one study, frank suppurative inflammation with abscess formation and even generalized peritonitis resulting either from primary inflammatory disease or torsion of the appendices epiploicae accounted for 18.6 per-

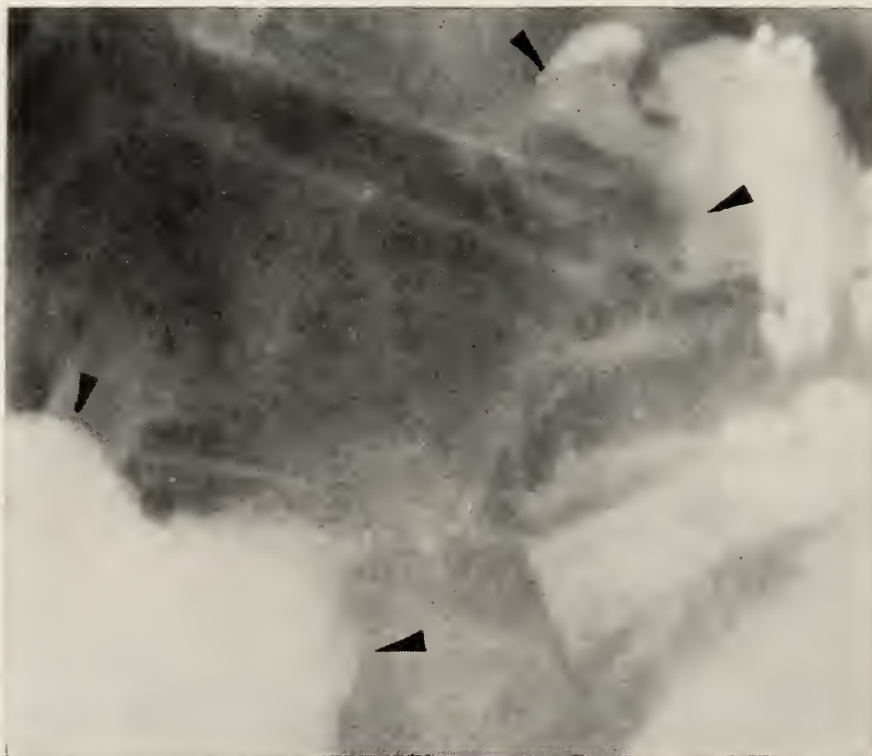


FIG. 2. Spot film of pseudotumor.



FIG. 3. Postevacuation film of splenic flexure region.

cent. The appendices epiploicae are situated along the entire colon from the cecum to the upper part of the rectum, and occasionally on the vermiform appendix. Torsion or vascular thrombosis causing an infarction of the appendices epiploicae may lead to stenosis of the bowel from constricting fibrosis. Interference with circulation may be acute or chronic, which may be followed by hemorrhage into the fatty tissue.<sup>6</sup> Secondary infection by bacterial invasion from the bowel may result in acute inflammation and suppuration.

The clinical findings in this patient of abdominal pain, emesis, change of bowel habits, and

weight loss, as well as the laboratory studies were of little help in the differential diagnosis.

The napkin-ring defect seen on the barium enema examination is not specific for annular carcinoma. The visualization of the intact mucosal folds is the most important and probably the only roentgen sign to rule out carcinoma. In many cases, demonstration of the mucosa at the narrowed segment is not adequate to indicate whether it is intact or destroyed. Therefore, for proper surgical management in such a case, benign inflammatory disease should always be included in the differential diagnosis.

### Summary

A case is presented which showed on barium enema examination a napkin-ring defect of the splenic flexure, identical to annular carcinoma of the colon. However, it was surgically proven to be a localized abscess with fibrosis and adhesions. The pathogenesis of acute suppuration with abscess formation is discussed. Pericolonic inflammation and adhesion should be included in the differential diagnosis of napkin-ring type defects.

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**PHENOBARBITAL IN CHOLESTASIS.** — In two children with intrahepatic cholestasis treated with phenobarbital (10 mg per kilogram of body weight per day) for four days, serum bile salt concentration decreased from 100 to 400 to 1 to 10  $\mu\text{g}$  per milliliter, and pruritus disappeared. The serum bilirubin concentrations were reduced to 20 to 50 percent of pretreatment values, and the <sup>131</sup>I-Rose Bengal fecal excretion increased during treatment. In contrast, phenobarbital had no effect on serum bile salts, bilirubin, <sup>131</sup>I-Rose Bengal excretion and pruritus in a child with extrahepatic biliary obstruction. Decreased serum bile salt concentrations and concomitantly increased fecal excretion of Rose Bengal in phenobarbital-treated patients suggest that the barbiturate stimulates bile secretion and biliary excretion of bile salts. It may be helpful in the management of young patients with intrahepatic cholestasis. —Adolf Stiehl, M.D.; M. Michael Thaler, M.D.; and William H. Admirand, M.D., San Francisco: *The New England Journal of Medicine*, 286:858-861, April 20, 1972.

# Maternal Mortality Report for Ohio – 1970

By THE OSMA COMMITTEE ON MATERNAL HEALTH

ONCE AGAIN the Committee on Maternal Health is proud to present this, its SIXTEENTH Annual Report for the year 1970. Periodically, this is compiled and published in compliance with a House of Delegates directive creating the Committee, establishing its functions and activities, and subsequent follow-up action by the OSMA Council, January 16, 1954.<sup>1</sup>

Divided into five sections, the first division outlines activities of your Committee since its last report to the Council on February 13, 1972.<sup>2</sup>

In the second part, several Committee projects are described representing developments to fulfill its assigned functions, while the third portion contains a detailed statistical summary gleaned from the Ohio Study during the year 1970. Covering maternal deaths in all 88 counties, the data includes not only hospitalized patients, but also those who "died at home." Part four summarizes and discusses the data, and finally, *recommendations* from your Committee are submitted based upon its experiences with "Maternal Health in Ohio."

## Activities

Twenty-one members comprise the Committee on Maternal Health. Geographically, they represent the Association's 11 Councilor Districts; professionally, they exhibit talent from the family physician as well as the specialties, eg, obstetrics and gynecology, anesthesiology, pathology, and internal medicine.

Two meetings of the Committee were held during 1972; a most successful two-day meeting in Granville, Ohio, January 15-16, 1972, and the 56th meeting was held June 25, 1972 in Columbus. As this document goes to press, plans are com-

pleted for the 57th meeting to be held in Granville, January 20-21, 1973.

During 1972, the Committee received and classified 38 cases for the Ohio Maternal Mortality Study, bringing the total on file to 1500. In evaluating responsibility and avoidability in each case, the base line of "ideal care" was established in "Guiding Principles."<sup>3</sup>

Serving on the Advisory Council to the Revisions Committee (O.D.H.) for rules governing licensure of Ohio maternity hospitals, were three members of your committee, eg, Drs. Brandeberry, Ramsayer, and Ruppertsberg; the revision document was completed in December. Likewise, two members of the Committee (Ramsayer and Ruppertsberg) continue to serve on the State Medical Board; four registered-nurse midwives were newly licensed, after the examinations in December 1972.

The Chairman had the pleasure of visiting hospitals and medical seminars in Sweden, Finland, and Denmark during a two-week (OSMA) adventure in Scandinavia in July 1972. In November, the Chairman presented a paper titled "Maternal Deaths Among Ohio Teenagers," at the Congress of the Pan Pacific Medical Association, Miami, Florida.

## Projects

The Committee continues to publish reports and articles in *The Journal* on a quarterly basis. Data and educational material from the Ohio Study is disseminated through this medium periodically.<sup>4</sup>

Brief reviews of material in this column also appear occasionally in a relatively new, annual publication, *Searle Survey of Obstetrics and Gynecology*.

Beginning with the 56th meeting and continuing with extensive correspondence, members of the Committee worked to revise "Guiding Principles for Obstetric Care."<sup>3</sup> This document was reprinted as the *fourth* revision, after approval by the Council, but it was not published in *The Journal*, due to a reservation of space therein for new scientific articles.

In order to provide voluminous, accurate statistics for information and education schedules

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\*A continuous statewide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.



maintained by the Committee, various data processing projects are programmed and completed (Table 1). Plans are being developed to adapt the IBM system for the computer, in order to facilitate data processing, all of this through coordination with the statistical division of Ohio Medical Indemnity Inc.

The Committee's award-winning exhibit ("Fatal OB Emergencies") displayed during the 1972 OSMA Annual Meeting (Cincinnati) drew an enormous amount of interest and attention from both medical and paramedical observers. Plans for the Committee's 1973 exhibit will be announced after the 57th meeting.

As in the past, the Committee and its various members continue close liaison with the well-established county maternal mortality studies. Six of these operate on an annual basis, in Cleveland, Columbus, Cincinnati, Dayton, Toledo, and Akron. Although coordinated with the State Study, these are supported by their respective obstetric-gynecologic societies, in cooperation with their county medical societies.

Statistics from the Ohio Maternal Mortality Study are published herewith. Terminology and nomenclature used in the study have been employed since their adoption in 1954. They follow closely those prescribed in *The International Classification*, and definitions recommended by the AMA and ACOG.

| Ohio Maternal Mortality Study                    |         |
|--|---------|
| Statistics for 1970                              |         |
| Total Live Births in Ohio, 1970                  | 199,781 |
| Total Cases in files, 16 years, 1955-1970 = 1500 |         |
| Total Cases Studied (1970)                       | 57      |
| Cases not studied due to lack of information     |         |
| Undetermined                                     | 0       |
| Maternal Deaths (Classified)                     | 45      |
| Non-white  | 13      |
| White  | 32      |
| Age:   |         |
| Teens (none below 15)                            | 6       |
| 20's   | 19      |
| 30's   | 17      |
| 40's   | 3       |
| Parity:  |         |
| Primigravidae                                    | 6       |
| Multiparae                                       | 34      |
| Unknown  | 5       |
| Place of Death:                                  |         |
| Hospital   | 37      |
| Home   | 7       |
| Other  | 1       |
| Type of Delivery:                                |         |
| Not recorded                                     | 0       |
| Operative  | 21      |
| Nonoperative (spontaneous)                       | 9       |
| Not delivered                                    | 15      |
| Route of Delivery:                               |         |
| Not recorded                                     | 1       |
| Vaginal  | 22      |
| Cesarean   | 7       |
| (antemortem)                                     | 6       |
| *(postmortem)                                    | 1       |
| Laparotomy (ectopic preg.)                       | 0       |
| *Not delivered                                   | 15      |

|  |    |
|--|----|
| Case Classification (when death occurred):                           |    |
| Not known  | 0  |
| Group I (fr. concept. to 20th wk.)                                   | 4  |
| Group II (fr. 20th wk. to 28th wk.)                                  | 2  |
| Group III (fr. 28th wk. through term)                                | 11 |
| Group IV (postabortal, postpartum)                                   | 28 |
| Autopsies.   | 33 |
| (includes 12 coroners' cases)  |    |
| Prenatal care (apparent from data sheets):                           |    |
| None   | 6  |
| Unknown or not reported  | 3  |
| Adequate   | 20 |
| Inadequate   | 9  |
| Excluded (ectopic preg. and abortion)                                | 7  |
| (Low socio-economic status=3)  |    |
| Classification of preventability:                                    |    |
| Nonpreventable   | 13 |
| Preventable (avoidable factor)                                       | 32 |
| Patient responsibility (P <sub>1</sub> )                             |    |
| Personnel responsibility (P <sub>2</sub> )                           | 13 |
| Both P <sub>1</sub> and P <sub>2</sub>                               | 4  |
| P <sub>3</sub> (Misc.)   | 2  |
| Classification of Primary Causes of Death:                           |    |
| Hemorrhage   | 9  |
| Abortion, without sepsis   | 0  |
| Abruptio   | 0  |
| Afibrinogenemia  | 0  |
| Abruptio   | 0  |
| Am. fl. embolus  | 0  |
| Dead fetus   | 0  |
| Ruptured uterus  | 0  |
| Atony, uterine, postpartum   | 4  |
| Ectopic pregnancy (without sepsis)                                   | 1  |
| Laceration, extrauterine   | 1  |
| Placenta praevia   | 1  |
| Retained placenta  | 0  |
| Ruptured uterus (no afibrin.)  | 1  |
| Other  | 2  |
| High Risk Related: 2, Non-Related: 2                                 |    |
| Infection  | 5  |
| Abortion, alleged "criminal"   | 4  |
| Abortion, septic, spontaneous  | 0  |
| Up. resp. inf.   | 0  |
| Peritonitis  | 0  |
| Septicemia (puerperal sepsis)  | 1  |
| Septicemia (other)   | 0  |
| Pyelitis-pyelonephritis  | 0  |
| High Risk Related: 0, Non-Related: 0                                 |    |
| Toxemia  | 3  |
| Acute yellow atrophy   | 0  |
| Hypertension, chronic (incl. hypertension with cerebrovascular hem.) | 0  |
| Eclampsia  | 3  |
| Renal disease  | 0  |
| Puerperal toxemia, not specified                                     | 0  |
| High Risk Related: 0, Non-Related: 0                                 |    |
| Other  | 28 |
| Amniotic fl. emb. (no hemorrhage)                                    | 5  |
| Anesthesia   | 3  |
| (general)  | 1  |
| (regional)   | 2  |
| Breast, carcinoma, metastatic  | 1  |
| Cardiac arrest   | 0  |
| Cardiac disease  | 3  |
| Cerebrovascular hemorrhage (no tox.)                                 | 1  |
| Diabetes   | 1  |
| Drug poisoning   | 1  |
| Dyscrasia, blood   | 1  |
| Ileus, paralytic   | 1  |
| Lower nephron-nephrosis  | 0  |
| Pulmonary edema  | 1  |
| Pulmonary embolus  | 5  |
| Suicide  | 1  |
| Other, unusual   | 4  |
| High Risk Related: 4, Non-Related: 5                                 |    |

TABLE 1. IBM Data Processing Projects by Number and Assignment—Three Years, 1970-1972.

| IBM Project | Assignment and Purpose  |
|-------------|---|
| No. 65      | Scan, case selection for future articles.   |
| No. 66      | Comparison, Ohio and Franklin County Cases, "Other Causes," Dr. R. L. Meiling's Foreign Address, February 1970. |
| No. 67      | Maternal Deaths, Guernsey County, Address — Dr. Ruppertsberg, April 7, 1970.                                    |
| No. 68      | Maternal Deaths, Summit County, Address — Dr. Charles Bowen, Akron.   |
| No. 69      | Maternal Deaths Due to Anesthesia (1971 Exhibit by the Committee).  |
| No. 70      | Maternal Mortality Report for Ohio — 1968 (Council and OSMJ). Also "Unusual Case" Project.                      |
| No. 71      | Maternal Mortality Report for Ohio — 1969 (Council and OSMJ).   |
| No. 72      | Fatal OB Emergencies (including scan). Maternal Deaths Involving Sickle Cell Anemia (Exhibit and Article OSMJ). |
| No. 73      | Maternal Deaths Due To Air Embolism (OSMJ)  |
| No. 74      | Maternal Deaths Among Ohio Teenagers, 16-Year Survey — Address, and Article, Dr. Ruppertsberg.                  |
| No. 75      | Maternal Mortality Report for Ohio — 1970 (Council and OSMJ).   |

During 1970, there were 199,781 live births in Ohio.<sup>5</sup> From this maternal mortality study, the Committee classified 45 maternal deaths for the year. The maternal mortality rate was 0.23 per 1000 live births, or 2.30 per 10,000 live births for 1970. This is the same rate reported for 1969.<sup>2</sup> Furthermore, Ohio reported 2,503 *stillbirths* (fetal deaths) during 1970, making the figure for *total births* 202,284.

Discussion

First, we note that the number of Ohio live births increased by 10,682 over the number reported for 1969.<sup>2,5</sup> And in a longer range of comparison, the number of live births in Ohio has *increased* each year since 1967.

With an increase in live births reported (1970) and 45 maternal deaths designated (there were 44 reported for 1969), the maternal mortality rates for these two years are exactly the same (0.23 per 1,000 live births). Among the 45 maternal deaths, there were *six* teenagers, none of whom was less than 15 years of age.

Fifteen patients (one-third) died undelivered; one patient had a *postmortem* cesarean section performed because of a dead fetus. There were *six ante mortem* cesarean sections; one patient with an ectopic gestation was diagnosed at autopsy. Autopsies were performed upon 75 percent of the patients; 12 were coroner's cases. Thirty-two (70

percent) of the maternal deaths were rated *preventable* with 13 assessed *personnel* responsibility.

Hemorrhage again leads the list as a single primary cause of death, with infection trailing as a second in questionable "rank"; amniotic fluid embolus and pulmonary embolism share the same number of cases (five).

Among the 45 maternal deaths, the Committee found 15 to be High Risk obstetric patients before pregnancy; of these *six* had a *cause of death related* to the High Risk condition. Two of them were due to hemorrhage and four came under "other causes," in classification.

Recommendations

1. Again the Committee recommends continuation of the Ohio Maternal Mortality Study with its allied educational facets.

2. Council, Committee members, and the general medical profession should strive to continue the coordination of related efforts with the Ohio Department of Health toward the improvement of "Maternal Health in Ohio."

3. Council is to be congratulated upon its efforts to secure funds that will provide for the transposition of the IBM data for the Ohio Study onto computer processing.

With genuine appreciation, the Chairman acknowledges the devotion and support of the Committee members who completed their duties effectively during the past year. On behalf of the Committee, the Chairman gratefully acknowledges assistance extended by the Council, attending physicians, representatives of the many county medical societies, the Ohio Department of Health, Ohio Coroner's Association, and numerous other agencies and individuals. Without their continued cooperation and support this Maternal Mortality Study could not have been completed.

Respectfully submitted,  
Anthony Ruppertsberg, Jr., M.D.  
*Chairman, Committee on Maternal Health*

Approved by The Council of the Ohio State Medical Association, January 28, 1973.

References

1. Maternal mortality study, statewide basis. *Ohio State Med J* 51:886-888, 1955.
2. Committee on Maternal Health: Maternal mortality report for Ohio-1969. *Ohio State Med J* 68:261-263, 1972.
3. Guiding principles for obstetric care. *Ohio State Med J* 53:1328-1329, 1957, (revised 1963 and 1972, reprinted, not published).
4. Committee on Maternal Health: Maternal deaths due to air embolism. *Ohio State Med J* 68:1105-1107, 1972.
5. Ohio Department of Health, Bureau of Vital Statistics. Special communication.

# Professional Activities



## Proceedings of The Council

Meeting of January 27-28, 1973

A REGULAR MEETING of The Council of the Ohio State Medical Association was held Saturday and Sunday, January 27-28, 1973, at the OSMA Headquarters' office, 17 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of The Council (except Dr. James C. McLarnan, Mt. Vernon); Dr. John H. Budd, Cleveland, a member of the AMA Board of Trustees; Dr. John W. Cashman, Columbus, Ohio Director of Health; Dr. Henry A. Crawford, Cleveland, AMA Delegate; Mr. James S. Imboden, Columbus, Assistant Director, Department of Field Service, AMA Division of Public Affairs; Mr. Bernard D. King, Columbus, Student AMA Representative; Mr. William J. Lee, Columbus, Administrator, Ohio State Medical Board; Dr. Richard L. Meiling, Columbus, Chairman, Ohio Delegation to the AMA; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Dr. Robert N. Smith, Toledo, AMA Delegate; Dr. Carl Mankowitz, Columbus, Assistant to Ohio Director of Health; Mr. Marc DeBard, Columbus, a guest of Mr. King; Messrs. Hart F. Page, Charles W. Edgar, Jerry J. Campbell, Robert D. Clinger, David L. Rader, Mrs. Katherine E. Wisse, Mr. R. Gordon Moore, and Mrs. Gail Dodson.

Those present Sunday were: All members of The Council (except Dr. McLarnan and Dr. John C. Smithson, Findlay); Dr. Budd, Mr. Imboden, Mr. King, Mr. Pohlman, Mr. DeBard; Dr. William C. Earl, representing Ohio Regional Medical

Programs; Dr. Anthony Ruppertsberg, Columbus, Chairman of the OSMA Maternal Health Committee, and all members of the OSMA staff, with the exception of Mr. Gillen and Mrs. Dodson.

### Minutes Approved

Minutes of the meeting of December 15-17, 1972, were approved.

### Councilor Reports

The Councilors reported on activities in their respective districts.

### Robert A. Lang, Ph.D., Honored

The Council adopted a resolution honoring Robert A. Lang, Ph.D., on his fifteenth anniversary of service to the Cleveland Academy of Medicine.

### Finance and Membership

Mrs. Wisse presented membership statistics and a progress report on membership data processing. The report was accepted.

### Auditing and Appropriations

Mrs. Wisse presented the minutes of the Building Committee meeting of December 17, 1972. The Council approved the minutes and approved the demolition contract involving the



razing of the hotel structure located on the Ohio State Medical Association property.

### American Medical Association

Dr. Meiling presented the minutes of the meeting of Ohio's AMA Delegation, which met with The Council January 26, 1973.

The Council confirmed the election of the following delegation officers: Richard L. Meiling, Chairman; P. John Robeck, Vice Chairman, and William R. Schultz, Co-Chairman.

The Council approved the delegation's position paper on "Report H" of the Council on Medical Education of the 1972 Clinical Session, entitled "Criteria for Acceptable Medical School."

The Council unanimously approved the AMA Delegation support for the re-election of John Budd as Trustee to the American Medical Association, and the appointment of Dr. Meiling as Dr. Budd's campaign manager.

Dr. Meiling reported on plans for the hospitality room in New York City and on activities of the AMA Long Range Planning Council.

Dr. Meiling and Dr. Budd were appointed as a committee to prepare a position paper for the Ohio Delegation on the Ohio resolution regarding the structure of the American Medical Association.

The Council voted to support the candidacy of Robert N. Smith, M.D., Toledo, for the AMA Council on Legislation.

### Ohio Medical Indemnity

Dr. Robeck, Dr. Lieber and Dr. Wells reported for the Liaison Committee to Ohio Medical Indemnity, Inc.

The Council revised the guidelines on the tenure of office by members of OMI Board of Directors to read as follows:

#### TENURE OF OFFICE BY MEMBERS OF OMI BOARD OF DIRECTORS

"1. Very careful attention should be given by the Nominating Committee to see that the board has representation from as many different geographical areas throughout the State of Ohio as possible.

"2. The directors should continue to be elected for one year at a time.

"3. The chairman of the Nominating Committee for the OMI Board of Directors should also serve on the Liaison Committee of the OSMA to OMI, Inc.

"4. It would be advisable to have all members of the Nominating Committee attend at least one meeting per year of the OMI Board of Directors."

### Annual Meeting

Mrs. Dodson presented a progress report on the Annual Meeting, Columbus, Ohio, May 6-9.

Mr. Campbell reported on exhibits.

In response to an invitation from Nationwide Insurance Company for an open house to show their Medicare operation during the Annual Meeting, it was The Council's opinion that this could be better scheduled at another time than the Annual Meeting.

### Constitution and Bylaws

Amendments to the Constitution and Bylaws of the Holmes County Medical Society were approved, subject to minor technical corrections.

### MAI-PSRO

Dr. Henry reported for the information of The Council on the meeting of the MAI Carrier Input Coordinating Committee, January 4, and the PSRO Council Meeting, January 6 and 7, 1973. He also discussed the meetings of the OSMA officials with HEW officials in Washington, D.C., January 16-17, 1973.

### Legal Counsel Report

Mr. Pohlman reported the chiropractic suit against the Ohio State Medical Association, Ohio State Medical Board and the American Medical Association has been concluded in favor of the Medical Board and the Medical Associations, since the U.S. Supreme Court refused to grant a writ of certiorari in connection with the chiropractors' appeal to the Supreme Court from the judgment in favor of the Board and the Associations.

With regard to proposed litigation against the Ohio Department of Public Welfare on auditing procedures, he indicated that the Department has agreed with the Ohio State Medical Association to make substantial changes in the auditing procedures and that further negotiations with the Department are in progress.

Mr. Pohlman's report was approved by The Council.

### Federal Legislation

Mr. Edgar discussed Ohio State Medical Association action on the N.B.C. network program, "What Price Health." He also reported on the American Medical Association Medcredit Bills, H.R. 2222 and S.R. 444. He announced that of the 126 sponsors, Ohio, at present, (January 27,) has seven: Congressmen Ashbrook, Powell, Guyer, Minshall, Wylie, Brown and Harsha.

## State Legislation

There was a general discussion of hospital licensure and certificate of need.

Governor Gilligan's "pay back proposal" involving selected students in the professions was **opposed** by The Council.

Mr. Rader reported on the following bills:

S.B. 29 and H.B. 126, measures to provide that the state pay interest on Medicaid bills which are unpaid after 30 days. (**Action:** Needs further study.)

H.B. 19, emergency medical technician licensure. (**Action:** Opposed under the moratorium on further licensing.)

H.B. 34, pre-marital blood testing for rubella. (**Action:** Referred to the Committee on Laboratory Medicine for study.)

H.R. 6, feasibility study for proposed Toledo Dental School. (**Action:** None.)

## Committee Reports

### Committee on Public Relations

Minutes of the November 1 meeting of the Committee on Public Relations were presented by Mr. Edgar.

Council authorized the committee to proceed with the production of a master kit of cassettes and slides in connection with the implementation of a VD education program.

Council authorized the publication of one issue of a four-page newspaper on a trial basis, at the projected cost of \$1400. The Council **approved** one sample mailing to members of the Association and asked that possibilities of a subscription price be studied by the committee.

The minutes were **approved as amended**.

### Committee on Government Medical Care Programs

Minutes of the January 10 meeting of the Committee on Government Medical Care Programs were presented by Mr. Page, in the absence of Mr. Gillen.

The Council **accepted** the committee's recommendation for study of the feasibility of including Medicaid recipient groups in the proposed class action suit against the Ohio Department of Public Welfare.

The Council **deferred action** on the committee's recommendation concerning the concept of "early and periodic screening, diagnosis and treatment," a state plan being developed under the aegis of the Ohio Department of Public Welfare. It was requested that further information be obtained and the matter docketed for discussion at the next meeting of The Council.

The minutes were **accepted as amended**.

## Ad Hoc Committee on Health Care Delivery Systems

Minutes of the January 17 meeting of the Ad Hoc Committee on Health Care Delivery Systems were presented by Mr. Page.

A message from Dr. Porterfield, Vice Chairman of the Committee, was presented via tape recording.

The Council **approved** the signing of the contract with the American Health Systems, Inc., for the development of a prototype of a statewide foundation encompassing general guidelines previously approved by the committee and voted that not to exceed \$10,000.00 be appropriated in the Ohio State Medical Association budget for this purpose. The Council also requested that the OSMA be reimbursed by Medical Advances Institute in this amount.

The minutes were **approved**.

## Joint Advisory Committee on Special Education

The minutes of the January 24 meeting of the Joint Advisory Committee on Special Education were presented by Mr. Clinger. The minutes were **approved** and incorporated in the approval were suggested revisions in medical aspects of program standards for special education to be submitted to the state superintendent of public instruction and president of the state board of education.

## Commission on Medical Education

The minutes of the January 24 meeting of the Commission on Medical Education were presented by Mr. Edgar.

The Council **approved** the Commission's recommendation that appropriate legislation to certify the physician's assistant be prepared by legal counsel and that such legislation be introduced in the Ohio General Assembly only at the discretion of The Council.

The Council commended Dr. Madigan for his report on the "Survey Report on Continuing Medical Education Among Ohio Physicians, 1972," and authorized its publication in *The Ohio State Medical Journal*.

The minutes were **approved**.

## Council Committee on Fee Review

The Council Committee on Fee Review report was presented by Dr. Bates. The report of the committee on Case No. 1 was **approved as amended**, and the reports on Cases No. 2 and 3 were **approved**.

## Grievance Case

The Council **approved** the use of the Academy of Medicine of Cincinnati and Hamilton

County as an arbitrator in a nearby county on a grievance case, subject to the approval of the county so involved.

### Dr. Cashman

Dr. Cashman addressed The Council on current developments in public health. He announced that there would be no change, in the immediate future, with regard to transfer of the Medicaid Program from the Department of Public Welfare to the Department of Health, but that legislation effecting such a change might be introduced by the Administration later in the session.

He announced substantial cuts would appear in the health budget due to phasing out of various programs and that there would be block health grants under "revenue sharing."

He discussed hearings on hospital licensure and certificate of need and said that next year the Governor would appoint Citizens' Task Forces on both health and education.

He also discussed the U.S. Supreme Court decision on abortions.

### Ohio State Medical Board

Mr. Lee announced that 71 formal hearings have been held and that enforcement procedures are moving in the Ohio State Medical Board.

He announced that funding of the Board program in the Governor's budget is adequate at this time.

### Regional Medical Program

Dr. William C. Earl, Columbus, a member of the Advisory Council of Ohio Regional Medical Programs, reported to The Council on the developments during the past year with regard to Regional Medical Programs in Ohio. The Council voted its thanks to Dr. Earl and accepted the report.

### Multiphasic Health Testing Programs

A set of "Guidelines for establishing and Operating Multiphasic Health Testing Programs," as established by the Committee on Judicial and Professional Relations, was presented on behalf of the committee by Mr. Page. The Council accepted as amended the guidelines and requested continued study and revision as necessary.

### 1970 Annual Maternity Mortality Report

The 1970 Annual Maternal Mortality Report for Ohio was presented by Dr. Anthony Ruppertsberg, Columbus, on behalf of the Committee on Maternal Health of the Ohio State Medical Association. The Council commended the committee, approved the report, and accepted it for publication.

### Maternity Hospital Regulations

Dr. Ruppertsberg, Chairman of the Committee on Maternal Health, was designated as the official representative from the Ohio State Medical Association to the hearings which will be held in connection with the adoption of revised maternity hospital regulations.

### Committee on Honorary Awards and Membership

The President appointed the following Committee on Honorary Awards and Membership: Dr. Clarke, Chairman; Drs. Wells, Tye and Thomas.

### Correspondence Re JAMA

Correspondence with regard to *The Journal of the American Medical Association* was received for information.

### Extendicare, Inc.

With regard to a request from Extendicare, Inc., a proprietary hospital development company, The Council felt that exhibits and advertising to recruit physicians for service in the areas where these hospitals are located would contribute to drain on medical manpower from Ohio.

### National Health Service Corps

The Council concurred in the approval by the Belmont County Medical Society of the National Health Service Corps application with respect to the placement of a physician in the Barnesville area. Such request was approved by the Belmont County Medical Society November 16, 1972 and the OSMA was so advised by the President of the Society January 4, 1973.

### Woman's Auxiliary Manpower Survey

With regard to the Woman's Auxiliary Manpower Survey, Council granted permission for the continuation of the survey and the compilation of data. The Council felt that it was unable to give assistance in the compilation, but signified its interest in the results when such are tabulated.

### Radio-Immuno Assays

A request for advice on publishing statewide notices regarding the availability of Radio-Immuno Assays at a hospital was considered by The Council. The Council advised that since this procedure is in no way unique and is available in every major city, such notices would not be necessary.



## Position Paper on Family Practice Legislation

The Council adopted the following position statement on proposed family practice legislation:

"OSMA reaffirms its policy of encouraging the development of family practice medical services in Ohio. OSMA recognizes that one of the cornerstones for the delivery of family practice medical services is a strong curriculum program in the state's medical schools for the education of their students in family practice. The development, modification and improvement of curriculum programs in family practice should be the ultimate responsibility of the leadership of the medical schools and should not be affected by legislative and political manipulation."

## Comprehensive Health Planning

It was the opinion of The Council that more information is needed concerning developments on comprehensive health planning. Dr. Fishman agreed to present summaries of all deliberations of the comprehensive health planning agency periodically to The Council of the Ohio State Medical Association.

## Future Meetings of The Council

The next meeting of The Council will be held Saturday and Sunday, March 17-18, 1973. An unstructured meeting of The Council and Dr. Cashman is scheduled for 10 a.m., Saturday, March 31 and will end mid-morning Sunday, April 1, at the Wooster Inn, Wooster, Ohio.

ATTEST: Hart F. Page  
*Executive Director*

## Health Departments May Refer VD Patients to Private Physicians

Through a private physician reimbursement system initiated by the Ohio Department of Health, licensed physicians can be reimbursed for the examination, diagnosis, and treatment of venereal disease patients, contacts, and suspects referred to them by the health department. Maximum reimbursement to the physician is ten (\$10.00) per patient.

This reimbursement system, now operational, enables health departments in areas throughout the State where free venereal disease services are not available, to refer patients, contacts, and suspects to medical attention. Additional venereal disease services provided through local health departments without charge include venereal disease drugs and laboratory services. This assistance is provided to ensure that no patient is denied venereal disease services because of inability to pay.

The Fort Steuben Academy of Medicine had as guest speaker for its February 13 meeting Dr. Stewart A. Fish, professor and chairman of the Department of Obstetrics and Gynecology, University of Tennessee College of Medicine, Memphis. His topic was, "Infectious Diseases Complicating Pregnancy, Practical Management." The meeting was held at the Steubenville Country Club.



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## NBC's Distorted Broadcast "What Price Health?"

ON LAST DECEMBER 19, the National Broadcast System aired nationwide a so-called documentary entitled "What Price Health?" The obviously distorted and biased program stirred up a hornet's nest, not only in the medical profession, but in public sentiment and among members of the Congress.

In a unique letter to Julian Goodman, President of NBC, Dr. William R. Schultz, OSMA President, protested the "misrepresentation, emotionalism and downright inaccuracy" of the broadcast. The uniqueness of the letter lies in the tactic of applying to the broadcast system the same restrictions that the network advocates applying to the medical profession.

Ohio, it might be said, has more than its share of interest in the broadcast. The sponsoring Eaton Corporation is based in Cleveland, Ohio, and one of the distorted case histories used in the broadcast had a Cleveland child as its subject.

In addition to Dr. Schultz's letter to the network, he also addressed a letter to the chairman of the board of the Eaton Corporation, registering a similar protest. Luther W. High, M.D., Millersburg, chairman of the OSMA Committee on Public Relations, also addressed a letter of complaint to Eaton Corporation.

Copies of Dr. Schultz's letter to NBC were sent to all Ohio Congressmen, Ohio's two U.S. Senators and to the Chairman of the Federal Communications Commission.

A powerful ally of medicine in this issue is Ohio Congressman Samuel L. Devine, who is the top ranking Republican member of the House Interstate and Foreign Commerce Commission. Congressman Devine is introducing legislation to regulate radio and TV networks. He is also asking the Federal Communications Commission for a full investigation of NBC broadcast "What Price Health?"

Many other medical organizations are registering protest.

In a communication dated January 10, 1973, Dr. Ernest B. Howard, Executive Vice-President of the American Medical Association, addressed a communication to Mr. Julian Goodman, President of the National Broadcasting Company, pro-

testing the lack of objectivity in the December 19 broadcast "What Price Health?" This letter and a formal complaint was sent by the AMA to the Federal Communications Commission. Copies also were well distributed among medical organizations and TV station managers across the nation.

Following is the text of the letter written by Dr. Schultz:

January 26, 1973

Mr. Julian Goodman, President  
National Broadcasting Company  
30 Rockefeller Plaza  
New York, New York 10020

Dear Mr. Goodman:

The Ohio State Medical Association would appreciate NBC's support of the Broadcast Security Act, which will be proposed as federal legislation to assure broadcast accuracy, quality, scope and public participation by setting up a federal program administered by the Federal Communications Commission.

Under this program, a Federal Radio and Television Institute would be established to fix standards, guidelines and regulations to govern all programs of the broadcasting industry.

Radio and television in most other nations enjoy the benefit of government control and/or government ownership in order that government policies and programs be accurately presented to the people. For their own good, the people are enabled to see newscasts and documentaries that are fashioned, directed and aired under direct government control. It is the purpose of our legislation to bring the benefits of all this government largesse to the poor, backward citizens of the United States.

Of course, this national institute will be made up of a majority of consumers. In order for the broadcast industry to be fully represented, each network will submit to the Chairman of the FCC the names of six vice presidents, from which he would select one for appointment to the Commission.

Since the costs of television and radio advertising have increased in recent years at a rate in



excess of the cost-of-living index, there will be levied a tax on all radio and television networks, all radio and television stations and all radio and television receivers.

There will be no advertising. Funds from the tax would be apportioned to the various networks and stations on a quarterly basis, with the amount determined by an efficiency rating system promulgated by the Institute.

All officers and employees, all newscasters, entertainers, commentators, writers, producers and directors, etc., will be placed on salary scales fixed by the Institute.

All of this would be carried out on a non-profit basis.

To paraphrase Senator Edward M. Kennedy, we in the United States have progressed far beyond the point where obtaining radio and television broadcast services, information and entertainment can be left as a matter of survival of the fittest. Caveat emptor, a wise admonition in dealing with the practices of many radio and television interests, can no longer be tolerated as an operating principle in obtaining protection from the broadcast industry. Such a principle is not in the national interest.

This proposed Broadcast Security Act would protect the American people from inaccuracy, misrepresentation, poor performance, callousness and excess profits in the broadcast industry by establishing a government-controlled, efficiently functioning broadcast system that would benefit all the people while controlling excessive and highly escalating costs.

What I have done so far, Mr. Goodman, is apply the same misrepresentation, emotionalism and downright inaccuracy to the broadcast industry as your network applied to my profession December 19, 1972.

I am referring to the NBC special entitled "What Price Health?"

This was a deliberate, planned distortion and misrepresentation of the medical and health care picture in the United States today. It was a tremendous disservice to my profession, to the health care industry, to the voluntary and private insurance industry, to existing government medical care programs and, above all, to the people.

For example, consider the gross misrepresentation of the Kurstin Knapp case in Cleveland as presented by NBC. This was depicted as being a cold, cruel, and inhuman treatment of a little girl whose life is not as important as money.

The true facts, Mr. Goodman, the true facts are that this little girl's problem was recognized immediately after her birth, her case was referred to an excellent pediatrician and a specialist in cardiovascular diseases was involved.

The child was too young for the very serious surgery she required, so she was watched very

carefully until she was old enough for an operation.

Further, although her father had been laid off at his place of employment, he was recalled to work with his medical and hospital insurance in full effect at the time of surgery on the child last November 8 by a widely recognized thoracic surgeon.

Even if there had been no private insurance, this child would have qualified for full assistance under the Ohio Crippled Children Program. Also, she would have qualified under the Aid to Dependent Children of the Unemployed. This child, regardless of her father's employment or unemployment, received the finest medical attention.

We produced all this accurate information regarding Kurstin Knapp in a matter of a few hours. A college journalism freshman could have done the same thing. Instead of producing accuracy, "What Price Health?" produced a travesty. And this is not the first time NBC health care "specials" have grossly and deliberately misrepresented the American health care picture.

Well-informed radio audiences and television viewers are concerned today with threats, some real and some implied, of a federal radio-TV takeover. I am one of these because I feel free expression is so essential to both the individual and the collective liberties of all Americans.

However, when the public is confronted with such inaccuracies, misrepresentations and diatribes as "What Price Health?" et al, one can not help but see an erosion of public support of your industry's right of self-determination. Why? The right of self-determination carries with it a moral and social responsibility that requires honesty and accuracy. **If the broadcast industry destroys the confidence of its audiences—the people—then the destruction of your independence is only a matter of time.**

And, speaking of destruction of independence, let us consider the legislation so highly touted as the great panacea for all health problems. Why does NBC, by airing such distortions as "What Price Health?" want to impose upon the American people the Kennedy plan—a national health care dictatorship?

That plan permits only a single source of payment—the federal government—for all providers of health care services and facilities. Does NBC equally advocate that all the radio and television be similarly controlled by the federal government?

Why does NBC advocate for the medical profession federal controls when federal controls are totally repugnant to the broadcast industry?

Why does NBC advocate legislation that would completely destroy one of the nation's major industries—the voluntary and private health insurance industry? If these policies are so terrible,



why does the broadcast industry accept dollars to air health insurance advertisements?

Why does NBC advocate destroying the nation's pharmaceutical industry? The Kennedy plan would do that.

Why does NBC advocate destroying the private, independent practice of medicine, particularly solo practitioners, partnerships and small group practices? The Kennedy plan would accomplish that.

Why does NBC advocate a totalitarian health care program that could cost the American family triple its present annual health care expenses? The Kennedy plan would do that.

Why does NBC so consistently support the Kennedy plan that proposes to take an additional \$38.5 billions from general revenues that already suffer an annual deficit of more than \$25 billions? The Kennedy plan would do that.

Why does NBC not investigate why the estimated costs of the Kennedy plan are four to six times greater than costs of other legislative proposals?

The United Nations Demographic Yearbook warns emphatically: "Lack of international comparability between area statistics arises primarily from differences in definition." Why does NBC wrongfully continue to cite false comparisons of United States health statistics with other nations in face of this strict international warning?

NBC most certainly would fight socialization of its industry. Why, then, does NBC so strongly advocate the Kennedy Plan, which is socialized medicine? "Socialized Medicine (is) any of vari-

ous systems to provide the entire population with complete medical care through government subsidization of medical and health services, general regulation of those services, etc." (Random House Dictionary of the English Language, 1966 unabridged).

Why doesn't NBC interview for a "special" Dr. Robert Myers, who is one of the world's foremost authorities on social insurance and who resigned as Chief Actuary of the Social Security Administration rather than permit himself to be muzzled by advocates of Kennedy-type legislation?

I recommend Mr. Goodman, that you read carefully Dr. Myers' book, *Medicare*, published by the McCahan Foundation, and *The Case for American Medicine: A Realistic Look at Our Health Care System*, by Harry Schwartz of *The New York Times*, David McKay Co., publisher. Also, please read *Hazardous to Your Health* by Marvin Edwards, Arlington House, publisher.

I have studied thoroughly the American Medical Association's letter addressed to you January 10, 1973. I endorse and support that letter whole-heartedly.

To repeat for emphasis, if the broadcast industry destroys the confidence of its audiences—the people—then the destruction of your independence is only a matter of time.

Sincerely,

William R. Schultz, M.D., President  
Ohio State Medical Association



Accredited by Joint Commission on Accreditation of Hospitals.

GUY H. WILLIAMS, Jr., M.D.  
Medical Director

G. PAULINE WELLS, R.N.  
Admin. Director

HERBERT A. SIHLER, Jr.  
President

MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

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# Obituaries

**Edward Henry Beilstein, M.D.**, Mansfield; Western Reserve University School of Medicine, 1943; aged 59; died January 22; member of OSMA, AMA, American Academy of Ophthalmology and Otolaryngology, and the American Academy of Facial, Plastic and Reconstructive Surgery; diplomate, American Board of Otolaryngology; practicing physician in Mansfield for a number of years, specializing in the EENT field, and founder of the Richland County Speech and Hearing Center; veteran of World War II.

**Miriam Bell, M.D.**, Toledo; Woman's Medical College of Pennsylvania, 1922; aged 77; died December 20; member of OSMA and AMA; after an early career as a medical missionary in China, practiced in Kentucky and Pennsylvania before moving to Toledo in 1951; formerly associated with the Toledo State Hospital.

**Charles Butrey, M.D.**, Lorain; George Washington University School of Medicine, 1954; aged 46; died January 21; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner in the Lorain area; active in affairs of Lorain County Medical Society, its former vice-president and former delegate to OSMA; veteran of World War II.

**Chalmer John Carothers, M.D.**, Cleveland; Western Reserve University School of Medicine, 1911; aged 87; died January 14; practitioner in the Cleveland area for more than 60 years; member of OSMA and AMA through 1967.

**William Daniel Grant, M.D.**, Cleveland; University of Colorado School of Medicine, 1943; aged 54; died January 7; member of OSMA, AMA, the American Academy of Ophthalmology and Otolaryngology, and the Association for Research in Ophthalmology; diplomate, American Board of Ophthalmology; practitioner for a number of years in Cleveland, specializing in ophthalmology; veteran of World War II.

**Fred H. Harris, M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1910; aged 86; died January 1; member of OSMA and AMA; practitioner in the Oakley-Cincinnati area for most of his professional career, engaging in general practice and industrial medicine; associated for many years with the Trailmobile Company.

**Harold F. Koppe, M.D.**, Dayton; Ohio State University College of Medicine, 1916; aged 79; died January 16; member of OSMA, AMA, and the Endocrine Society; Fellow, American College

of Physicians; practitioner in Dayton for more than 50 years before his retirement; past president of the Montgomery County Medical Society.

**Harry Braham Leslie, Sr., M.D.**, Cleveland; Johns Hopkins University School of Medicine, 1928; aged 68; died January 3; member of OSMA, AMA, and the American Academy of Pediatrics; diplomate, American Board of Pediatrics; practitioner in Cleveland for 38 years before his retirement last year; veteran of World War II. Among survivors is his son, Dr. Harry B. Leslie, Jr., also of Cleveland.

**Elmer Troy McCune, M.D.**, Sebring; Wayne State University School of Medicine, 1938; aged 65; died January 20; member of OSMA and American Academy of Family Physicians; practitioner in the Mahoning County community for about 30 years; veteran of World War II.

**Wallace C. Madden, M.D.**, Dayton; Jefferson Medical College of Philadelphia, 1930; aged 68; died December 27; member of OSMA, AMA, American Academy of Family Physicians, and Industrial Medical Association; practitioner in the Dayton area for 42 years.

**William U. Neel, M.D.**, Middletown; University of Cincinnati College of Medicine, 1939; aged 59; died January 14; member of OSMA and AMA; practitioner in the Middletown area for some 26 years, specializing in general surgery; veteran of World War II.

**Manson E. Nichols, M.D.**, Lancaster; Western Reserve University School of Medicine, 1926; aged 74; died January 8; recent member of OSMA and AMA; practicing physician in the Lancaster area since 1932.

**John Victor Pilliod, M.D.**, Ft. Myers, Fla.; University of Cincinnati College of Medicine, 1921; aged 74; died January 10; member of OSMA and AMA; practitioner for many years in the Grand Rapids, Ohio, and Toledo area; retired about 1964; past president of the Wood County Medical Society. Among survivors is a son, Dr. James Pilliod.

**Barnie Murl Reagan, M.D.**, Cleveland; University of Tennessee College of Medicine, 1931; aged 70; died January 5; member of OSMA and AMA; practitioner for more than 28 years in the Cleveland area, specializing in the EENT field.

*(Continued on Next Page)*



**John Harold Shanklin, M.D.**, Springfield; University of Kansas School of Medicine, 1939; aged 64; died December 30; member of OSMA, AMA, and American Academy of Family Physicians; practicing physician and surgeon in Springfield for many years and former medical director of the Ohio Masonic Home; former chairman of the OSMA Section on General Practice; past president of the Clark County Medical Society; veteran of World War II.

**Stanley Carlyle Sneeringer, M.D.**, Baltimore, Ohio; Ohio State University College of Medicine, 1935; aged 62; died December 28; member of OSMA and AMA; practitioner in Fairfield County for about 35 years.

**Dwight Sinclair Spreng, Sr., M.D.**, Cleveland, Western Reserve University School of Medicine, 1923; aged 75; died January 12; member of OSMA and AMA; practicing physician and surgeon for many years in Cleveland before his retirement. Three physicians are among survivors,

a son, Dr. Dwight S. Spreng, Jr.; a daughter, Dr. Katharine Waldmann; and a stepson, Dr. Thomas Waldmann.

**George Newton Wenger, M.D.**, Massillon; Medical College of Ohio at Cincinnati, 1909; aged 87; died December 29; member of OSMA, AMA, and American Proctologic Society; Fellow, American College of Surgeons, and International College of Surgeons; diplomate, American Board of Colon and Rectal Surgery; practitioner for a total of 62 years, with 51 years in the Massillon area; past president of the Stark County Medical Society.

**Daniel E. Wertman, M.D.**, Cleveland; Western Reserve University School of Medicine, 1949; aged 47; died January 6; member of OSMA and AMA; Fellow, American College of Radiology; diplomate, American Board of Radiology; practicing radiologist in Cleveland and associated with St. Luke's Hospital; president-elect of the Cleveland Radiological Society; served in the Army Medical Corps, 1954-1956.

## Discussion of E.N.T. Case of the Month

*(continued from p. 188)*

In most instances, the cause for hoarseness can be seen by looking at the patient's larynx. The larynges of children may be seen by using a mirror and the indirect method in the majority of cases. However, it is quite important to explain to the child exactly what you are going to do, and what you expect of him. A few "practice runs" without the use of the mirror are helpful, letting him phonate the high pitched "eee" necessary to get a good view of his larynx. Heating the mirror to prevent fogging will frequently cause great apprehension to a child unless the reason is explained to him. Let him touch the mirror and prove to him that it is only warm, not hot prior to inserting it into his mouth.

This child was found to have bilateral vocal nodules (singers nodes) as shown in Figure 1. These are characteristically located at the junction of the anterior and middle third of the vocal cord and are frequently bilateral. The nodules prevent approximation of the true cords during phonation resulting in the typical hoarse, low-pitched voice.

Vocal nodules are usually the result of vocal abuse, and after surgical excision (done through



Fig. 1. Vocal nodules usually occur at junction of anterior-middle third of true cords.

the laryngoscope under general anesthesia), it is important to correct the original speech problem or they may reoccur. Speech therapy and the avoidance of vocal abuse are important adjuncts in the patient's postoperative management.





**Placidyl®**

(ETHCHLORVYNOL)

## Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated for short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients for possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. Administer with caution to patients with suicidal tendencies and do not prescribe large quantities of the drug. Adjustment of dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addictive patients or those who are likely to increase doses of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported in long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuance of the drug. Drug dosage should be limited in elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is added in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported in the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients respond unpredictably to barbiturates or alcohol or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, syncope without marked hypotension. Transient illness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, drowsiness, facial numbness, and allergic reaction manifested by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 302430R



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**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anti-coagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Watch initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylureas, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activities requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), patachias, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, paravascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hypoglycemia, thyroid hyperplasia, toxic goiter, association of hypothyroidism and hypothyroidism (causal relationship not established), agitation, confusion, states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

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# The Ohio Program for Peer Review — MAI-PSRO

By JAMES L. HENRY, M.D.

President of MAI and Secretary-Treasurer of OSMA

THE Ohio State Medical Association's Council in 1971 carefully analyzed the Bennett Amendment to H.R. 1. This evaluation in concert with expert congressional advice determined that the PSRO (Professional Standards Review Organization) concept would prevail over status quo, roll-back and the AMA-PRO (Professional Review Organization).

Through H.R. 7182—the Devine-Betts Bill—the OSMA was able to modify the Bennett proposal.

## MAI Established

The Ohio State Medical Association then formed Medical Advances Institute (MAI), a corporation not for profit, established by OSMA, with a qualifying board of trustees, both lay and physician. This corporation, in the opinion of lawyers, qualified as the proper vehicle for the Professional Standards Review Organization. The PSRO council, which is the basic physician element of the corporation, functions under the corporate body—MAI.

The efforts made and knowledge gained through study of the legislation were employed by MAI to develop a peer review program that would be compatible with anticipated legislation.

It is safe to say that the game of anticipation is still in progress. The 1972 law—P.L. 92-603—is nonspecific in many areas and will be modified and enforced by regulations from the U.S. Secretary of Health, Education and Welfare. Medicare has demonstrated that a law by regulations may be very distressing. MAI-PSRO is left with more of the game of anticipation. At this point, it is very costly and not very exciting, merely exacting.

## Sincere Philosophical Differences

A great deal has been written and expostulated about MAI-PSRO. It is safe to state that a great deal of ignorance, fear and concern have been demonstrated. In fairness, some very sincere philosophical differences have been raised. Certain elements did, indeed, mount a vigorous campaign against the concept of PSRO. This opposition demanded that OSMA must have approval of its House of Delegates. In May 1972, the OSMA

House of Delegates, by an overwhelming majority, endorsed the concept and development of a program. There was a restrictive stipulation that the House must approve any operational contract with government agencies.

The action of the OSMA House of Delegates has been emphatically respected to the letter. No manner of grants has been accepted from any government agency. The development of a quality, quantity and cost assurance program is extremely expensive and the temptation to seek such a grant is very pressing: But **NO! NO!** To date the peer review system and organization have been supported by OSMA, Blue Shield, Blue Cross, Nationwide Insurance Company and the Columbus District of the Ohio Association of Osteopathic Medicine. Less than \$30,000 has been expended to date for a program that was funded by HEW in Utah for \$1,200,000. Necessity becomes the mother of invention, I.O.U.'s and ideas.

In Ohio a program that is physician-directed, flexible and variable has been created. To this end, 12 PSRO regions have been formed. Each region has a representative on the PSRO Council. Three councilors-at-large serve to make an effective democratic council of **15 licensed, practicing physicians**. These physicians were selected upon recommendation of County, State and Specialty Societies. The construction of the Council in this manner under a state (area) wide umbrella, precludes multiple PSRO's in Ohio. Under P.L. 92-603, in the event that three or more independent PSRO's exist, the PSRO State Council will be comprised of physicians chosen by the Secretary of HEW, the Governor, Hospital Associations, the State Medical Society and the Regional PSRO's. Historically, this may not serve the State of Ohio well. The MAI umbrella certainly is more appropriate.

Rules and regulations have been adopted by the MAI Council and attention is being directed to regional organization and relationships with local Medical Societies and hospital staffs.

## Panels Will Establish Guidelines

Specialty panels have been established to develop guidelines and parameters of quality medical



care by disease entity. Each panel was instructed to develop medical criteria for 20 diseases and/or procedures. To date, almost 100 items have been developed and 25 have been programmed for the computer technique. The work of the panels is most important and on-going.

The panels will evaluate, revise and improve the criteria of care as the data are generated for study. Also, panels will be important resource professionals for the PSRO Council in policy and research matters.

In addition to the specialty panels, the PSRO Council and the MAI Board of Trustees have input from a carrier coordinating committee and a hospital coordinating committee. These committees provide necessary expertise unavailable except from such resources. The carrier coordinating committee is comprised of representatives from all of the Ohio Blue Cross Plans, OMI, Medical Mutual of Cleveland, Nationwide, the Health Insurance Council, along with officials from the Ohio Departments of Health, Finance and Welfare. At the present time, this committee is addressing itself, seriously, to the development of a common billing form and data reporting form. Accomplishment of this would greatly improve data for the PSRO as well as improve the caliber of the data greatly. At present, hospitals and other facilities are confronted with 95 or more separate forms, of which none captures identical data. For example, one form doesn't ask the patient's name, nor does another request a diagnosis. One form alone would be a miraculous contribution.

The determination of appropriate costs is inextricably correlated and tied to quality assurance. This certainly requires the opinion and advice of hospital administrators. The Hospital Coordinating Committee will have deep concern in the area of costs. The linking of the claims payment mechanism to the quality review process is the best assurance of accurate, timely reporting so that retroactive decisions can be reduced or eliminated. Even more important, problem cases will be identified readily. For example, no charges are appropriate if quality review determines that the patient should never have been admitted at all. Hospital administrators appreciate that a great deal of expense is due to information handling. With the PSRO system, a great savings could be effected for both hospitals and carriers.

### Physician Direction

The end result of the work of all of this is a physician-directed, computerized peer review system. This mechanized system is simply a review process based upon standard quality criteria developed by practicing physicians and applied statewide with local variables and assuring uniform application and methodology. In this way effi-

ciency and effectiveness of local peer review programs are enhanced.

The means have been found to define discrete computer-adapted quality criteria, which possess adequate specificity to allow the initial case review to be totally machine processable. The creation of "uniform criteria development forms" permitted the establishment of specific data requirements for all disease criteria.

### Efficient Data Handling

The several medical specialty panels have been instructed in the techniques of so defining the necessary elements of quality medical care and are currently completing those criteria forms. The criteria, including length-of-stay parameters and developed for disease entities in all specialty areas of medicine, are thus defined uniformly and utilize identical data fields. This, then, enables the principles of true peer review to be built into the concurrent computer screening of hospital abstracts and permits development of effective data handling procedures. It is apparent that there has been a parallel development of uniform quality criteria, case abstracts and the necessary computer programs to process the data.

Once the admitting diagnosis is entered into the computer, usually within the first 24 hours, the machine automatically generates a case abstract unique to the diagnosis. The case abstract is derived **entirely** from criteria developed by the Professional Standards Review specialty panels. The case abstract for the individual patient is completed or updated periodically by a nurse-coordinator from the time of admission to discharge.

### Personal Follow-Up

The computer does the bookkeeping of individual case information, informs the nurse-coordinator precisely what additional data may be needed to fulfill the peer review quality criteria and automatically prepares analysis, including exception reports which are issued to the utilization review committees for their evaluation. In most cases, concurrent abstracts will be generated every six days but, if the need arises, a report could be developed instantaneously.

The employment of trained nurse-coordinators for collection of data enhances the accuracy greatly and obviously frees hospital personnel from these work requirements. This approach also ensures that the information has been collected by a "disinterested party," inasmuch as the nurse is an employee of the PSRO and not the hospital nor the hospital staff.

Confirmed data accuracy is essential to our plans for a continuing process of criteria refine-



ment and upgrading of the entire review process. For example, the length of stay criteria required by P.L. 92-603 will most certainly be altered from the present 50th percentile as a result of quality review. Criteria will be readjusted in keeping with facts gleaned from the data, so that the accurate realities of medical practice can be identified.

The system necessitates a level of appropriateness of action at all levels and stages of the review process. In order to establish credulity, responsibility and integrity, checks have been designed throughout the informational system from input to the final judgmental decision rendered by utilization review committees.

The mechanism for evaluation of results of the entire peer review system is built in and will be available for independent scrutiny and for determining the appropriateness of hospital costs.

The peer review system is designed to perform a prospective, current and retrospective evaluation of the quality, quantity and cost of medical care by individual, physician, hospital, state, region and above all, disease entity. The utilization and audit functions are simultaneous. Herein lies the real difference and, thus, the effectiveness of the computerized peer review system.

Those involved in the progress that has been made are:

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(Continued on next page)

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Tennyson Williams, M.D., Delaware  
James B. Patterson, M.D., Lorain  
Emmett P. Monroe, M.D., Cuyahoga Falls  
Jack M. Strickler, D.O., Dayton

## Specialty Panel on Ob-Gyn

Arthur G. King, M.D. (Chm.), Cincinnati  
Karl Ziesmann, M.D., Cincinnati  
John H. Sanders, M.D., Cleveland  
George P. Leicht, M.D., North Olmsted  
Layton S. Shaffer, D.O., Columbus

## Specialty Panel on Ophthalmology

Robert B. O'Dair, M.D. (Chm.), Columbus  
Torrence A. Makley, Jr., M.D., Columbus  
Alfred Nicely, M.D., Akron  
James E. Walker, D.O., Sandusky  
Jerome A. Gans, M.D., Cleveland  
S. Baird Pfahl, M.D., Sandusky

## Specialty Panel on Pediatrics

Homer A. Anderson, M.D. (Chm.), Columbus  
Dwain Harper, D.O., Columbus  
Mason S. Jones, M.D., Dayton  
Marvin R. McClellan, M.D., Cincinnati  
Lowell D. Smith, M.D., Chillicothe  
Robert O. Walton, M.D., Cleveland

## Specialty Panel on Orthopedics

James G. Roberts, M.D. (Chm.), Akron  
Joseph E. Burns, Jr., M.D., Warren  
Richard G. Jenkins, M.D., Dayton  
Carl R. Coleman, M.D., Columbus  
Thomas H. Brown, Jr., M.D., Toledo  
Gordon N. Farner, M.D., Cleveland  
Richard J. Watkins, M.D., Wooster  
Peter E. Johnston, D.O., Columbus

## Specialty Panel on Pathology

Lawrence J. McCormack, M.D. (Chm.), Cleveland  
Horace B. Davidson, Jr., M.D., Columbus  
Philip Golding, D.O., Columbus  
John Hamblet, M.D., Cincinnati  
R. Daniel Rigal, M.D., Toledo  
Robert E. Schultz, M.D., Wooster

## Specialty Panel on Physical Medicine

John L. Melvin, M.D. (Chm.), Columbus  
William Scott, D.O., Columbus  
Emily Hess, M.D., Cincinnati  
Paul A. Nelson, M.D., Cleveland  
Ira W. Weiden, M.D., Toledo  
Karl Olson, M.D., Akron  
Leo H. French, Jr., M.D., Dayton  
John D. Guyton, M.D., Columbus

## Specialty Panel on Plastic Surgery

H. William Porterfield, M.D. (Chm.), Columbus  
John D. Desprez, M.D., Cleveland  
George Henry Dietz, M.D., Youngstown  
James B. Kahl, M.D., Cincinnati  
John C. Kelleher, M.D., Toledo  
Lester R. Mohler, M.D., Columbus  
Philip Weisman, M.D., Dayton

## Specialty Panel on Radiology

Theodore Castele, M.D. (Chm.), Cleveland  
John J. Gaughan, M.D., Cleveland  
Joseph H. Hanson, M.D., Toledo  
Willard J. Howland, M.D., Canton  
William Schwartz, M.D., Columbus

## Specialty Panel on Psychiatry

(No chairman)  
Victor M. Victoroff, M.D., Cleveland  
Robert J. McDevitt, M.D., Cincinnati  
R. V. Fitzgerald, M.D., Toledo  
Robert L. Turton, D.O., Columbus

## Specialty Panel on Surgery

John H. Hughes, M.D. (Chm. Pro tem), Kenton  
Thomas Morgan, M.D., Gallipolis  
F. Miles Flickinger, M.D., Lima  
Nathan Hale, M.D., Wilmington  
William Flynn, M.D., Youngstown  
Elden Weckesser, M.D., Cleveland  
J. Albert Finer, D.O., Massillon  
Frank Shively, M.D., Dayton  
Robert Hummel, M.D., Cincinnati  
George N. Bates, M.D., Toledo  
Clare W. Elliott, D.O., Dayton  
Theodore F. Classen, D.O., Cleveland

## Specialty Panel on Urology

Thomas N. Quilter, M.D. (Chm.), Marion

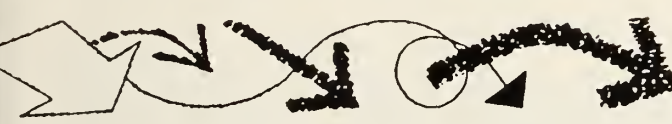
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James Dorn, Blue Cross of Central Ohio  
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Sidney Lewine, Director, Mt. Sinai Hospital of Cleveland, Cleveland  
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*Mark Russell*

Subject:  
**"POLITICS IS A LAUGHING  
MATTER"**

**TUESDAY, MAY 8, 1973—11:30 A.M.**

(Week of the OSMA Annual Meeting)

**Saturn Room, Second Floor,  
Sheraton-Columbus**



WHAT MARK RUSSELL does is to say salient things about big people, Establishment people and their big institutions . . . things some of us would like to say but don't dare . . . or just aren't bright enough to say them. So, we're happy that Mark says his things so well — even rymes and sings them. Further, he slices into the absurdities of life so that you can almost ride them. He attacks his topics with zest and glee, tummeling out of his incisive comedic talent. He turns satire into hilarity. You don't feel you've been enlightened by Mark but you **NOW** you've been entertained.



**OMPAC LUNCHEON RESERVATION  
TUESDAY, MAY 8, 1973 — 11:30 A.M.**

Enclosed is \$\_\_\_\_\_ to pay for:

\_\_\_\_\_ OMPAC Luncheon tickets @ \$5.00 per person

Name\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_

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Mail to: OSMA, 17 South High Street, Suite 500, Columbus, Ohio 43215



# “Sexual Counseling”

TO BE PRESENTED IN CONNECTION WITH  
1973 OSMA ANNUAL MEETING

Monday, May 7, 1973  
Veterans Memorial Building

Program sponsored by the OSMA Sections on Obstetrics and Gynecology; Physical Medicine and Rehabilitation; and Psychiatry and Neurology.

NOTE: program is acceptable for 6 prescribed hours by the American Academy of Family Physicians.

| Morning Program  | Afternoon Program   |
|--|---|
| Presiding: Karl Ziesmann, M.D., Cincinnati, Chairman, Section on Obstetrics and Gynecology   | Presiding: Ian MacLean, M.D., Columbus, Program Chairman, Section on Physical Medicine and Rehabilitation   |
| Panel Moderator: Mary S. Calderone, M.D., M.P.H., New York City  | Panel Moderator: Mary S. Calderone, M.D., M.P.H., New York City   |
| 9:00 a.m. “Human Sexuality and the Practicing Physician”   | 2:00 p.m. “Counseling Sexual Incompatibility: Adam versus Eve”  |
| Speaker: Mary S. Calderone, M.D., M.P.H., Executive Director and Co-Founder Sex Information and Education Council of the U.S. (SIECUS) | Speaker: David M. Reed, Ph.D., Philadelphia, Pa., Assistant Professor of Psychiatry and Chief of Training, Division of Family Study, University of Pennsylvania |
| 9:45 a.m. “A Tolerant Attitude Toward Human Sexuality”   | 2:45 p.m. “Sexual Counseling of the Physically Disabled”  |
| Speaker: Edward A. Tyler, M.D., Visiting Professor, Family Practice, University of Wisconsin School of Medicine, Madison, Wisconsin.   | Speaker: Theodore M. Cole, M.D., Associate Professor, Department of Physical Medicine & Rehabilitation, University of Minnesota.                                |
| 10:30 a.m. Coffee Break  | 3:30 p.m. Coffee Break  |
| 10:45 a.m. Panel discussion followed with Questions and Answers Period   | 3:45 p.m. Panel discussion followed with Questions and Answers Period   |
| 12:15 p.m. Break for lunch and tour of Exhibits  | 5:00 p.m. Adjourn   |

*Register Now for I, II, III or IV*

# Four Postgraduate Courses

SCHEDULED TUESDAY AND WEDNESDAY MORNING

7:30 A.M. -- 9:00 A.M.

SHERATON-COLUMBUS MOTOR HOTEL

During 1973 OSMA Annual Meeting

## COURSE I

### **"Ischemic Heart Disease I— Diagnosis"**

**Course Leader:** Richard P. Lewis, M.D.  
Associate Professor, Department of Medicine  
Ohio State University, College of Medicine

**Program—Tuesday, May 8**

- (1) "History & Physical Examination"—  
Richard P. Lewis, M.D.
- (2) "Overview of Problem"—  
Richard P. Lewis, M.D.
- (3) "Exercise Tests"—Stephen F. Schaal, M.D.  
Associate Professor, Department of Medicine  
Ohio State University, College of Medicine
- (4) "Lipids"—Paul D. Bunn, M.D.  
Associate Professor, Department of Medicine  
Ohio State University, College of Medicine
- (5) "Coronary Angiography"—  
Richard F. Leighton, M.D.  
Associate Professor, Department of Medicine  
Ohio State University, College of Medicine

### **"Ischemic Heart Disease II— Therapy"**

**Program—Wednesday, May 9**

- (1) "Saphenous Vein Graft"—  
John S. Vasko, M.D.  
Associate Professor, Surgery  
Ohio State University, College of Medicine

- (2) "Medical Rx of Angina Including Rehabilitation"—John L. Robinson, M.D.  
Assistant Professor, Department of Medicine  
Ohio State University, College of Medicine
- (3) "Cardiogenic Shock"—  
Charles A. Bush, M.D.  
Associate Professor, Department of Medicine  
Ohio State University, College of Medicine
- (4) "Arrhythmias"—Joseph M. Ryan, M.D.  
Professor, Department of Medicine  
Ohio State University, College of Medicine

## COURSE II

### **"Blood Gases: Acid-Base Disturbances, Fluid Electrolyte Problems"**

**Program—Tuesday, May 8**

"Diagnosis and Treatment of Acid-Base Disorders"

**Program—Wednesday, May 9**

"Diagnosis and Treatment of Fluid & Electrolyte Disorders"

**Course Leader:** Thomas F. Ferris, M.D.  
Professor of Medicine and Director of the  
Division of Renal Diseases  
Ohio State University, College of Medicine

*(Continued on Next Page)*

Four PG Courses—contd.

### COURSE III

#### “Parathyroid and Thyroid Problems and Solutions”

Course Leader: Thomas G. Skillman, M.D.  
Professor of Medicine, Director  
Division of Endocrinology & Metabolism  
Ohio State University, College of Medicine

#### “Thyroid Problems”

Program—Tuesday, May 8

Moderator: Ernest L. Mazzaferri, M.D.  
Associate Professor, Department of Medicine  
Ohio State University, College of Medicine

7:30-7:45 a.m. “Spectrum of Adult Thyroid Disease” (Simple Goiter, Thyroiditis, Graves’s Disease, Cancer)—Jack M. George, M.D.  
Associate Professor, Department of Medicine  
Ohio State University, College of Medicine

7:45-8:00 a.m. “The Thyroid Function Tests: Their Problems”—  
Thomas G. Skillman, M.D.

8:00-8:15 a.m. “Treatment of Thyrotoxicosis”—  
Ernest L. Mazzaferri, M.D.

8:20-9:00 a.m. Panel Discussion—Questions and  
Answers—Drs. Mazzaferri, George and  
Skillman

#### “Calcium-Parathyroid Problems”

Program—Wednesday, May 9

Moderator: William B. Malarkey, M.D.  
Assistant Professor, Department of Medicine  
Ohio State University, College of Medicine

7:30-7:45 a.m. “Spectrum of Parathyroid Diseases” (Hyperparathyroidism, Hypoparathyroidism)—Robert L. Folk, M.D.  
Associate Professor of Medicine,  
Division of Endocrinology and Metabolism  
Ohio State University, College of Medicine

7:45-8:00 a.m. “Diagnosis of Hyperparathyroidism”—William B. Malarkey, M.D.

8:15-8:30 a.m. “Treatment of Hypercalcemia”—  
Samuel Cataland, M.D.  
Assistant Professor, Department of Medicine  
Ohio State University, College of Medicine

----- Clip and Complete Registration Form and Return OSMA -----

#### POSTGRADUATE COURSES

Tuesday, May 8 and Wednesday, May 9, 1973

7:30-9:00 A.M.

Sheraton-Columbus Motor Hotel

(Please check one)

Please register me for Postgraduate Course

☐ I ☐ II ☐ III ☐ IV

Registrant's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Registration Fee: \$10.00 per person (includes continental breakfast)

Enclosed is a check in the amount of \$ \_\_\_\_\_

Make checks payable to the OHIO STATE MEDICAL ASSOCIATION and return to:

**Ohio State Medical Association**  
17 South High Street, Suite 500  
Columbus, Ohio 43215  
Attn: PG Courses



## COURSE IV

### “Current Concepts in Antibiotic Therapy”

**Course Leader:** Samuel Saslaw, M.D., Ph.D.  
Pomerene Professor of Medicine and  
Professor of Medicine and Microbiology  
Ohio State University, College of Medicine.  
Certified by the Board of Internal Medicine  
and the American Board of Microbiology.

#### Program—Tuesday, May 8

- 7:30-8:00 a.m. “The Newer Antibiotics and  
Their Role in Present Day Therapy”
- 8:00-8:15 a.m. Open Discussion. Questions and  
Answers
- 8:15-8:45 a.m. Practical Approach to the Ther-  
apy of:
- (a) Upper Respiratory Infections
  - (b) Lower Respiratory Infections
  - (c) Cardio-vascular Infections
- 8:45-9:00 a.m. Open Discussion. Questions and  
Answers

#### Program—Wednesday, May 9

- 7:30-8:00 a.m. Practical Approach to the Ther-  
apy of:
- (a) Central Nervous System Infections
  - (b) Urinary Tract Infections
  - (c) Gram-negative Sepsis
- 8:00-8:15 a.m. Open Discussion. Questions and  
Answers
- 8:15-8:45 a.m. “Common Sense Approach to  
Infections in Critically Ill Patients when  
Etiology is not Known”
- 8:45-9:00 a.m. Open Discussion. Questions and  
Answers

---

Programs at the University of Kentucky Col-  
lege of Medicine in the near future include the  
following: Pregnancy Complications, March 15-  
17; Pulmonary Thromboembolism, April 19-21;  
Cardiac Diagnosis and Treatment, April 30-May  
1; and Pediatric Radiology, May 2-4. Details may  
be obtained from Frank R. Lemon, M.D., Asso-  
ciate Dean for Continuing Education, College of  
Medicine, University of Kentucky, Lexington, Ky.  
40506.

## MDs in the News

Dr. Josef Warkany, Cincinnati, is one of  
three physicians cited and slated to share in the  
\$255,000 Child Health Award sponsored by the  
Charles H. Hood Foundation for his contributions  
to the present and future health of children. A  
professor of pediatrics in the University of Cin-  
cinnati College of Medicine, Dr. Warkany is asso-  
ciated with a number of pediatric projects in the  
Cincinnati area, among them the Children's Hos-  
pital Research Foundation.

Dr. Joseph M. Foley, Cleveland, has been  
named chairman of the Medical Advisory Board  
of the National Multiple Sclerosis Society. He is  
coordinator of postgraduate medical education at  
Case Western Reserve University, and is in charge  
of neurology outpatient services at University  
Hospitals.

Dr. Walter A. Hoyt, Jr., director of the  
Orthopaedic Departments at Akron City Hospital  
and Akron Childrens Hospital, was installed as  
president of the American Academy of Ortho-  
paedic Surgeons at the organization's recent an-  
nual meeting in Las Vegas.

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(See Page 235)

# MAKE YOUR HOTEL RESERVATIONS For The 1973 OSMA Annual Meeting

## COLUMBUS, OHIO

### MAY 6-9

Leading Downtown Columbus  
Hotels at Prevailing Rates

#### SHERATON-COLUMBUS MOTOR HOTEL

50 North Third Street  
(OSMA Headquarters)

|         |                   |
|---------|-------------------|
| Singles | \$19.00 - \$31.00 |
| Twins   | \$26.00 - \$38.00 |

#### NEIL HOUSE MOTOR HOTEL

41 South High Street  
(OSMA Overflow Hotel)

|         |                   |
|---------|-------------------|
| Singles | \$14.00 - \$23.00 |
| Doubles | \$18.00 - \$28.00 |
| Twins   | \$19.00 - \$26.00 |

#### SOUTHERN HOTEL

South High and East Main Streets

|         |                   |
|---------|-------------------|
| Singles | \$12.00 - \$13.00 |
| Doubles | \$15.00 - \$16.00 |
| Twins   | \$15.50 - \$20.00 |

#### CHRISTOPHER INN

300 East Broad Street  
(Woman's Auxiliary Headquarters)

|         |         |
|---------|---------|
| Singles | \$15.50 |
| Doubles | \$20.00 |
| Twins   | \$23.00 |

#### HOLIDAY INN - DOWNTOWN

175 East Town Street

|         |         |
|---------|---------|
| Singles | \$15.00 |
| Doubles | \$20.00 |
| Twins   | \$20.00 |

All rates subject to change. If you plan to share a room, please indicate name of roommate.



### HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

\_\_\_\_\_  
(Name of Hotel)

\_\_\_\_\_  
(Address)

Columbus, Ohio

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 6-9, 1973 (or for period indicated).

|                   |                            |
|-------------------|----------------------------|
| _____ Single Room | _____ Twin Room            |
| _____ Double Room | Other Accommodations _____ |
| Price Range _____ | Guaranteed _____           |

Arrival: May \_\_\_\_\_ at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Departure: May \_\_\_\_\_ at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

#### PLEASE VERIFY MY RESERVATION

Name \_\_\_\_\_

Address \_\_\_\_\_

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# You BETCHA I'm going to Scioto Downs How About You?



TUESDAY, MAY 8, 1973  
6:30 P.M.

MAKE YOUR RESERVATION...TODAY!!

## Annual Meeting Pre-Registration and Ticket Form SOCIAL FUNCTION TICKET RESERVATIONS

Note: (No tickets reserved without money)

Make checks payable to: Ohio State Medical Association  
Mail this form to: Ohio State Medical Association, 17 South High Street,  
Suite 500, Columbus, Ohio 43215

Tuesday, May 8, 11:30 A.M.

"OMPAC LUNCHEON"

Sheraton-Columbus Hotel

\$5.00 per person

Number \_\_\_\_\_

Tuesday, May 8, 6:30 P.M.

"OSMA'S NIGHT AT SCIOTO DOWNS"

Scioto Downs, 6000 South High St.

\$12.50 per person

(Special Price to all Exhibitors of \$9.00 per person)

Number \_\_\_\_\_

Name \_\_\_\_\_  
(Please Print)

Address \_\_\_\_\_  
(Number and Street) (City) (State)

I am:  
☐ OSMA Member ☐ Medical Student  
☐ Non-Member Physician ☐ Guest

Other \_\_\_\_\_  
(Fill in)

Do You Belong to OMPAC?

☐ Yes

☐ No

Please prepare guest badge for my spouse.

\_\_\_\_\_  
(Please print name)



## Ohio's Jack Lewis Heads AMPAC Board

### OMPAC Praised for Punchy Membership Pitch

The Ohio Medical Political Action Committee can stand and take two big bows.

It's chairman, William J. Lewis, M.D., Dayton, has been elected chairman of the board of the American Medical Political Action Committee, based in Chicago. Dr. Jack Lewis has been a member of the Board of Directors of OMPAC since 1966 and chairman of the board for the past two years. He succeeds Dr. Hoyt Gardner of Louisville, Ky. as chairman of the national organization's governing board.



Wm. J. Lewis, M.D.

OMPAC's second bow would be in recognition of the following accolade tossed in Ohio's direction by the AMPAC publication *Across the Boards*:

"OMPAC, the Ohio Medical Political Action Committee, gives a short but punchy membership pitch in its most recent publication. An information-packed brochure entitled 'OMPAC scored well in 1972 Election,' chronicles OMPAC's election successes, outlines OMPAC's structure and candidate supporting procedures, and promotes

OMPAC-AMPAC active membership. Hats off to W. J. Lewis, M.D., OMPAC Chairman, and his fine Board of Directors and staff for this sure-to-be successful brochure."

\* \* \* \* \*

The AMA Medcredit bill had 127 sponsors in Congress within a week after its introduction. It's S 444 and HR 2222.

\* \* \* \* \*

The following comment by Henry J. Taylor, columnist who refuses to pull his punches, makes a lot of sense:

"Failure to vote is a cop-out on responsibility," says Taylor, continuing: "It is, moreover, a disastrous cop-out when you realize that apathy and abstention are the real creators — the actual makers of the Government of the United States. Again and again the balance of power rests with the stay-at-homes. In fact, a good question to ask anyone who complains about our country is: Did you vote?"

\* \* \* \* \*

Taylor, quoted above, didn't give the figure, but only 55 percent of those eligible to vote exercised that privilege last November 7.

Did you vote is not the only question which should be put to the dissatisfied citizen (physician, perhaps). After some research and soul-searching, he should be prepared to answer these questions: If you did vote, did you vote intelligently? Did you have facts concerning the reliability and views of the candidates who got your vote? Did you do any campaigning for those candidates who would have made good office-holders but lost out by a close vote to inferior opponents.

**HAVE YOU MADE YOUR 1973 OMPAC-AMPAC CONTRIBUTION?**

—Ohio Medical Political Action Committee

# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

**F**ORTY YEARS AGO, in the small community of Winder, Georgia. "Doctors' Day" was born. It was the inspired idea of Mrs. Charles B. Almond, a doctor's wife, who from childhood had been greatly impressed with the devotion and dedication of the medical profession. She had always carried fond memories of the gentle kindness of her family physician whose skill and understanding endeared him to his patients, both as doctor and friend.

Subsequently, as a doctor's wife, she shared the dedication of her husband and became convinced that medicine is the greatest profession on earth. This respect and appreciation inspired her back in 1933 to present to her local auxiliary the idea of having a special day on which to honor the doctors. And the idea took hold — with tremendous enthusiasm. The first "Doctors' Day" observance was held on March 30, 1933, in Barrow County, Georgia. And March 30 was chosen because it was the day that the famous Georgian, Crawford W. Long, M.D., had first used ether anesthesia in surgery.

On May 10, 1934, the plan was presented and adopted by the Georgia State Medical Auxiliary. In Atlantic City at the June, 1934 convention the plan was presented to the Woman's Auxiliary to the American Medical Association and the resolution adopted. In 1958, the Congress of the United States passed a resolution commemorating "Doctors' Day" and designating March 30

as a day to be observed annually, on which to honor members of the medical profession.

The red carnation is the symbol of "Doctors' Day." Centuries back, it's spicy fragrance was used in seasoning dishes "to preserve the body of men, both in mind and spirit." From the juice of its petals, a wine was made "that did comfort the heart of man." The meaning of the flower is divine rejoicing because it is said to have appeared on earth for the first time when Christ was born.

On the fortieth anniversary, come March 30, the Woman's Auxiliary salutes with love and appreciation the men and women of the medical profession this Doctors' Day, 1973.

## Doctor-Husbands—please read!

I asked Mrs. Louis Loria, Ohio Auxiliary President, if she would send me a special message to tie in with the observance of Doctors' Day this month, and to be passed on to you via this Auxiliary Highlights column. This she has not only graciously and beautifully done, but has incorporated into it a meaningful and provocative "dialogue":

"To you doctors who read this column (or those of you reading it because your wives just showed it to you), I wish to share some of my thoughts and convictions concerning you as doctors in the medical profession and as husbands and fathers in a family unit.

"As has already been detailed in this column, March 30 is a special day set aside to honor you.

---

## THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

---

### *President*

Mrs. Louis Loria  
Box 331, R. D. 1  
Bristolville, 44402

### *First Vice-President*

Mrs. Jack Weiland  
313 Rumson Dr.  
Englewood, 45322

### *Recording Secretary*

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### *President-Elect*

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Mrs. Paul Hahn  
122 Moore Ave.  
New Philadelphia, 44663

In observance of this day, I want to commend the doctors of Ohio for the high quality medical care that we have in this state. There is no doubt that you are a dedicated, caring and certainly hard-working group of professionals. Your patients frequently demonstrate how much they appreciate the kind of care you give them—how grateful they are for the role you play in ministering to them and their families in many of the crucial times of their lives. You are held in a unique position of esteem and love.

### “Almost ‘God-like’ ”

“We, as wives, recognize and appreciate this ‘almost God-like’ image your patients have of you. Nor is it very hard to detect the considerably less frequent times that you may experience ingratitude from a patient, rather than the more usual affection and gratitude. All of it does have an effect on you and we try to understand. If at times we seem not to understand or care, forgive us.

“Even though we are proud of your dedicated, caring qualities, your family also knows you as a human with fallibility, and if we sometimes topple you ungraciously from your ‘pedestal’, forgive us for this. Understand that it may even serve to keep a balance in your life that you need!

“Your family knows the amount of time and energy you give to your profession and, because of this, knows there are many adjustments in family living we must make. Let us be told sometimes that you appreciate our efforts. When we fail in these adjustments or do so only grudgingly, again forgive us.

### Family Unit

“The family is a vital unit of society, so let’s all do what we can to make the time we have together as families ‘quality time’ in terms of love, happiness and security. Since the time with your family is necessarily limited, use some of it to let us share what we can of your work. Keep us up on interesting developments in the medical field, encourage us to belong and participate in the activities of the Woman’s Auxiliary. This can be a strong link of mutual interest and sharing.

“Much needs to be done in health education of the public. Stimulate us, your family, to use our time and talents in this area, or other health care areas. Encourage us (both wives and children) to be knowledgeable and to speak out for the best interests of Medical Care.

“As wives, we are proud of you for your commitment to the practice of medicine and the freedom to do it where and how you wish. We pray that we can help to keep it that way and yet have medical care available to all who need and seek it.

“Our prayers and our love, this Doctors’ Day—and every day!”

### AMPAC

The Annual AMPAC Workshop was held in Washington, D.C. March 10 and 11 at the Washington Hilton. Among the speakers were George Bush, U. S. Ambassador to the United Nations and chairman of the Republican National Committee, and Robert Strauss, chairman of the Democratic National Committee. Mrs. Malachi W. Sloan, II, OMPAC Board member and North-Central Regional Legislative Chairman, has promised to send in a full story on the workshop which she will have attended (remember, this column is being written in February!)

In the meantime, Jane Sloan has another important and timely message to pass on and here it is:

“Now is the time to gear up for ’74! Political activity is a ’round the clock endeavor. Elections are won **between** election days. Individual political activity on the part of individual physicians (and wives) is desirable and commendable and necessary. However it is not enough. . . . Pooling of the interest, activity and money of many, many, many—through the Ohio Medical Political Action Committee is what gives a real boost to the medical profession’s interest in good government and makes the profession a potent factor in political action. . . .

“1973 is a new year, a new Congress, a new HEW administration and a new leadership of both political parties (that’s the lead line, says Mrs. Sloan, of the announcement of the AMPAC Public Affairs Workshop that was held in Washington, D.C.) A very exciting thought—1973 is a new year—and March is the month in which auxiliaries make a special effort on behalf of OMPAC.

“It is time to RENEW membership or become a new member and this is your special invitation to send your dues—\$25.00—to the Ohio Medical Political Action Committee, P.O. Box 5617, Columbus, Ohio 43221. It is as easy as that for doctors’ wives to back their husbands and the other physicians who strive to send the best men and women to the Congress of the United States or to the State Legislature.

“Any candidate earning OMPAC’s support has had his record carefully scrutinized. Physicians all over the state have reviewed the candidates’ views on social, economic and public health-medical issues. In Ohio, we can be proud of the record for OMPAC did score well in the elections of ’66, ’68, ’70 and ’72. In 1972, OMPAC had an overall 70 percent winning score (92 percent in the U. S. Congressional races; 75 percent in



the State Senate contests; 66 percent in the Ohio House battles.)

"Now it's another year. . . . Get in tune with the times and be a viable part of the political process in Ohio. The auxiliary goal is 100 OMPAC members. Be a NEW one in '73—or be a RE-NEW-ed one in '73. . . ."

### Here and There

The Franklin County auxiliary reports that its December 6 Christmas party at the State Hospital was most successful. The cookies and bingo prizes were furnished by the auxiliary members. A record player was given to the ward by Frances Fung, Leone Furste, Anna Keith, Mary O'Leary, Mary Lohrman, Angela Schmidt, Mufide Temizer and Violet Whieldon.

Another of the group's community service during the Holiday Season was the entertainment brought to the patients of Medcenter—Franklin's "Glee Club-ette" with Helen Tetirick at the chord organ. The punch and decorated cup cakes were made by Azelia Lausa and Mary Lohrman. Christmas gifts were hand-knit slippers, patchwork lap robes and needlework, the handiwork of auxiliary members Jean Hurd, Giny Conn, Collette Dierker, Betty Kefauver, Bonnie van Fossen, Giny Bolton, Holly Slivinski and Verna Brehm. Attractive favors were placed on the trays of the patients.

The January 16 luncheon meeting of the Franklin auxiliary was held at the Scioto Country Club. It was an unusual program—"Jewels of the Bible" presented by Robert W. and Jeffery Johnson of Johnson's Diamond Cellar. The program was arranged by Joan Fulton. Hostesses were Maxine Meagher and Anne Saylor.

A net profit of \$1,206.25 has been realized during a one-year period on the sale of watches (I might mention these watches are obtained from a "special" firm in New York, are most unusual and attractive and reasonably priced. Originally, a project alone of the Cuyahoga County auxiliary, it has now become not only a favorite and wonderful "money maker" for many Ohio county auxiliaries but also for those throughout the country—all through the generosity and cooperation of the member who made it possible, Florence Kaplan of Cleveland).

### Their Twenty-Fifth

Just a few months ago, the Ottawa County auxiliary celebrated a happy event—its twenty-fifth anniversary. Invited to participate in the celebration were members from the Sandusky and Lucas auxiliaries. The reception, luncheon and program were held at the Catawba Island Club at Port Clinton.

Special guests included: Mrs. Louis Loria, state auxiliary president; Mrs. Merritt Huber, fourth district director; and Mrs. Daniel S. Wolff, state membership chairman. Karen Messner, a member of the Port Clinton Civic Playmakers, gave a program of readings of contemporary poetry. "I am waging a one-woman crusade to get people to listen to poetry," she told her audience, adding that "the oral interpretation of poetry can be a moving and touching experience."

Mrs. Loria's talk was keyed to the state auxiliary's theme for the year, "Improving the Quality of Life." She discussed several things that each woman could do within her family to carry out the objectives of the theme. One was to stress better nutrition by improved eating habits. Another was for each woman to study her attitudes about taking a pill every time she feels uncomfortable or having a drink to liven up every social gathering.

"If we feel we have to take a drug to make us feel good or a drink to liven up the party, this may be what our children will think they should do," she said.

Mrs. Gordon R. Ley and Mrs. James I. Rhie were co-chairmen of the anniversary meeting. Mrs. Robert Reeves and Mrs. Robert W. Minick carried out the silver theme with bouquets of yellow and bronze mums in silver containers, and silver punch bowls. Mrs. Patrick Hughes, Ottawa president, Mrs. Burton Nelson, Lucas president and Mrs. John Zimmerman representing Sandusky, gave resumes of the activities of their individual groups.

### Just Over the Horizon

What is just over the Horizon? What else but the annual convention on May 7, 8 and 9 of the Woman's Auxiliary to the Ohio State Medical Association! Christopher Inn in Columbus will set the scene for the work sessions and the fun sessions. For all the exciting details, read next month's column!

## M.D. Biennial Registration Required Under Ohio Law

Doctors of medicine licensed to practice in Ohio are reminded that they are required to apply to the State Medical Board for a certificate of biennial registration on or before the first day of each odd-numbered year, and 1973 is such a year.

Section 4731.281 of the Ohio Revised Code reads in part as follows:

"Every doctor of medicine licensed to practice medicine or surgery within this state shall, on or before the first day of January of each odd-numbered year, apply to the state medical board for a certificate of biennial registration with the board upon an application which shall be furnished by the board, and shall pay at such time a fee of ten dollars to the board."

That same section of the Code specifies that failure to register as required shall operate automatically to suspend the physician's certificate to practice.

The Medical Board last fall mailed to all registered physicians applications for registration,

mail going in each case to the last known address.

Physicians who have not complied with the foregoing requirement should contact the Board immediately. Communication should be addressed: State Medical Board, State of Ohio, 21 W. Broad Street, Columbus 43215.

Registration for doctors of osteopathy is described in Section 4731.37 of the Revised Code.

A gift of \$8000 from the Hotel and Restaurant Employees and Bartenders International Union to the University of Cincinnati College of Medicine is supporting research on the relationship of polyamines to cancer. This is the sixth annual gift from the union to UC. The contributions, now totalling \$48,000, all have been used for research projects in the Department of Internal Medicine, directed by Dr. Richard W. Vilter.

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**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4-en-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism.

Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

| INDICATION   | Average Daily Dosage Tablets |
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| Postpubertal cryptorchidism  | 30 mg.                       |

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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## Watch Exaggerated Claims About Updating X-Ray Units, Federal Bureau Warns

The following communication dated January 17 was forwarded for publication in *The Journal* by John C. Villforth, Director, Bureau of Radiological Health, a branch of the Food and Drug Administration.

\* \* \*

You will recall that the Food and Drug Administration's Bureau of Radiological Health has responsibility for developing and administering a radiation control for health and safety program as authorized by Public Law 90-602. Under that program, a radiation safety performance standard for diagnostic x-ray equipment was published on August 15, 1972, to become effective one year later.

The Bureau recently learned that some dealers have been advising physicians and other users that all existing x-ray equipment will have to be upgraded to meet requirements of the standard by the effective date of August 15, 1973. You may be able to perform a service for your readers by informing them that **such advice is contrary to fact.**

Upgrading of x-ray equipment now being used is not now required by the standard. State and territorial radiation control authorities have been asked by the Bureau to so inform equipment users and dealers.

Our communication to the States and territories made one other point. This was that, although equipment now in use will not have to be modified before the standard becomes effective, owners installing manufacturer-certified components in such x-ray systems after next August 15 must install components of the type called for by the Federal standard.

Additional information about the standard may be obtained from the Division of Electronic Products, Bureau of Radiological Health, Food and Drug Administration, 12720 Twinbrook Parkway, Rockville, Maryland 20852.

## Medical College at Toledo Again Will Increase Enrollment

The Medical College of Ohio will increase the size of its 1973 entering class to 64 students — double the number in the Charter Class that entered the new school in September 1969.

This was the report given at the January

meeting of the MCO trustees by Dr. Robert G. Page, provost for academic affairs.

"We recognize the increase will strain all our facilities, especially in the clinical areas," Dr. Page told the trustees, "but we feel it is a necessary step to meet our responsibilities to the community and the state."

MCO accepted 32 students for each entering class in 1969 and 1970. In 1971 and 1972, the entering class was increased to 48 students.

The planned opening of MCO's new \$12-million Basic Science building this spring will provide physical space for the increase to 64 students. Additional requirements will include faculty recruitment, detailed planning of future clinical facilities and strengthened relationships with community hospitals and physicians, Dr. Page said.

Dr. Page also told the trustees that the Medical College had just received full accreditation from the American Medical Association and the Association of American Medical Colleges.

To become "fully accredited," a college must meet nationwide standards for educational and administrative services, and must have graduated its first class of doctors.

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**(See Page 227)**



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Box (insert number), c/o The Ohio State Medical Journal  
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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OHIO, FAIRFIELD, Space available in modern Medical Building, 15 miles from Cincinnati. General Practitioner and Specialist needed. Reply to Box 616, c/o The Ohio State Medical Journal.

GROUP FAMILY PRACTICE—Excellent opportunity for family practice in pleasant, progressive town near Columbus, Ohio. No OB; well-equipped medical center, 5200 sq. ft., including twelve examining rooms, small surgery, own laboratory and x-ray; three GPs already in practice; part-time coverage of college health service; modern well-equipped 350-bed community hospital with active consulting service and ER group 4 miles from office; excellent local schools. Salary plus percentage first year. Write to Granville Medical Center, Inc., Granville, Ohio 43023.

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio, Phone 271-0291.

WANTED: FAMILY PHYSICIANS, ORTHOPEDISTS, ENT, OB-GYN, PEDIATRICIAN, CARDIOLOGIST. ALL SURGICAL SPECIALTIES. All new medical center adjacent to new 206-bed hospital. All specialties plus strong family practice nucleus. Many shared services. Computer. Lease. Potential buy-in. Start up financing available. Reply Box 669, c/o Ohio State Medical Journal.

EMERGENCY ROOM PHYSICIAN WANTED—Community Hospital—Cleveland, Ohio 30-40 hours per week—\$15.00 per hour. Preferable, but not mandatory: American Graduate with some Family Practice experience. Required: Ohio license, personal interview, 30 day probation period—after which, contract, benefits, etc. negotiable. Contact: John A. Heppl, M.D., 5163 Broadway, Cleveland, Ohio 44127.

STAFF PSYCHIATRIST: salary depending upon qualifications and experience, one month paid vacation. Contact Thomas Di Mauro, M.D., Director, Stark County Mental Health Center, 618 Second St. N.W., Canton, Ohio 44703, or call collect 216/455-9407.

CHILD PSYCHIATRIST to develop, direct new children's services. Salary depending on qualifications and experience. Full or part-time to allow for private practice may be considered. Contact Thomas Di Mauro, M.D., Director, Stark County Mental Health Center, 618 Second St. N.W., Canton, Ohio 44703 or call collect 216/455-9407.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

OHIO, AKRON: Exciting opportunity for psychiatrist interested in taking over an out-patient private practice. Net income \$40,000 and up. Consultation to local agencies, hospital privileges, teaching also available. Contact Box 670 c/o Ohio State Medical Journal.

VACATION CONDOMINIUM — New Smyrna Beach, Fla. — just south of Daytona and away from the crowds, but enjoying the same beautiful beach. Two bedrooms, 2 baths. wall-to-wall carpeting, completely and tastefully furnished including linens, color TV and dishwasher. HEATED POOL, and sauna. \$400 per month. For reservations or further information, contact Wm. W. Conner, M.D., 517 Lakeshore Dr., Eustis, Florida 32726. Phone 904-357-5715.

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## CLASSIFIED ADVERTISEMENTS

(Continued from Previous Page)

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**HEALTH COMMISSIONER**—City-County Health Department in Southwest Ohio has an opening for an energetic physician to be health commissioner for a county of 83,000 population. Salary range \$20,000-\$25,000. Contact Mr. E.J. Demmitt, 557 State Rt. 504, Troy, Ohio 45373. Phone 513/335-8973.

**WANTED LOCUM TENENS** for busy family practice large city Northeastern Ohio, 2-3 months summer and fall 1973. Keep all you make over expenses; should net between \$3000 and \$4000 per month. Stay on if you like it, take over practice in short time. Send curriculum vitae and references to Box 671, c/o Ohio State Medical Journal.

**HOUSE PHYSICIANS MEDICAL AND SURGICAL ECFMG CERTIFICATE REQUIRED.** Board eligibility desirable. Salary commensurate with training and experience. Fringe benefits include paid hospitalization, uniforms, meals, and malpractice insurance. Contact: Dept. of Medical Education, Lakewood Hospital, 14519 Detroit Road, Lakewood, Ohio 44107.

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**VIRGIN ISLAND RENTAL (WATER ISLAND)** Spectacular location, well furnished, available year round, minimum two weeks for responsible couple, includes '72 VW, details: Robert L. Turton, 111 W. Third Avenue, Columbus, Ohio 43201.

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**IMMEDIATE OPPORTUNITY** due to death of physician. Large general practice available in Cleveland suburb. Complete with modern equipment and patient records. Contact: R. Zelvy, Cleveland 216-696-4600.

**FAMILY PRACTICE** — Overworked solo-practitioner, FFAFP, desires association or group practice with alternating work and vacation schedule. Will also consider emergency room or industrial work. Central or Southern Ohio. Box 672, c/o Ohio State Medical Journal.

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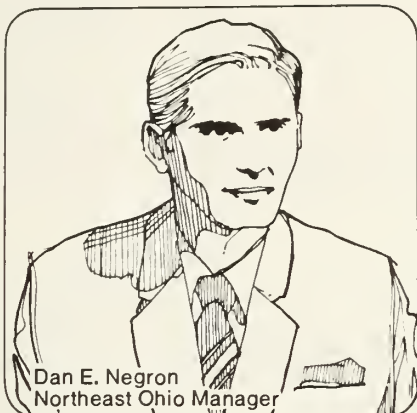
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**PHYSICIANS NEEDED IN NORTH CENTRAL OHIO.** Immediate openings in general practice and in internal medicine in rural area. Will provide space and arrangements. New hospital facilities. Contact Hardin County Medical Society, c/o Hardin Memorial Hospital, Kenton, Ohio 43326.

**WANTED:** Board certified or eligible Ob-Gyn with military obligation completed to associate with certified Ob-Gyn in central Ohio. Salary with bonus first year—full partnership after two years. Modern hospital. Contact: Benjamin Zolo, M.D., 1320 Granville Rd., Newark, Ohio 43055. Phone 614/344-1196.

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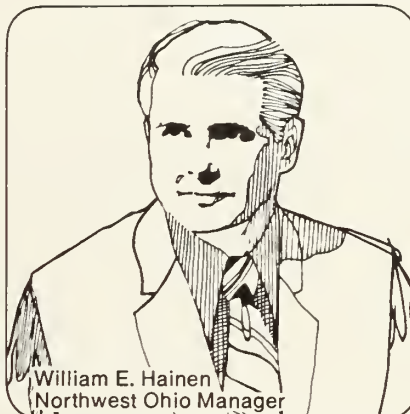
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**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debili-

tated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or over-sedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the

elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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# *The Ohio State* **MEDICAL JOURNAL**

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

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|--|------------------------------|
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## How Ohio Physicians Feel About Physician Assistants

THE USE OF NONPHYSICIANS as assistants has expanded greatly in recent years with the introduction of new allied health professions. This has resulted in new professional organizations which have certified and registered the graduates of programs as well as those experienced in various fields. In addition to being recognized by new or existing health professional organizations, many of these disciplines are referred to as "physician assistant" which is the most dominant of the new types of health manpower.

Much confusion exists regarding the purpose, definition and use of the physician assistant. The variance is so great that the term may be considered "generic" rather than referring to a "specific" discipline.

As of December 31, 1972, Health Careers of Ohio had identified 161 different types of "physician assistant" programs throughout the country. Courses of study range in length from 12 weeks to two years and more. In Ohio, nine programs have been identified. Others have been reported.

The definitions most generally accepted are those introduced in May, 1970 by the National Academy of Sciences which are:

**Type A. Assistant** has the ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment.

**Type B. Assistant** possesses exceptional skills in one clinical specialty, or, more commonly in certain procedures within a specialty.

**Type C. Assistant** is capable of performing a variety of tasks over the whole range of medical care, but does not possess the medical knowledge necessary to integrate and interpret the findings.

### In Ohio

Ohio currently has no provision for governmental licensing or registration of "Physicians' Assistants," and various health groups have been attempting to survey Ohio physicians to determine the present and future use of this form of health professional.

In 1970, the physician assistant and new types of health manpower were studied by the Health Manpower Committee of the State Advisory Council, Ohio Office of Comprehensive Health Planning, Department of Health, State of Ohio.

In January, 1971, the Ohio Office of Comprehensive Health Planning published a report prepared under a special projects grant titled, "The Contribution of Non-Physician Health Workers to the Delivery of Primary Care," by Amasa B. Ford, M.D., and David P. Ransohoff. Included in the text of the summary and conclusions were the following statements: "The new movement has the potential of opening up more rewarding careers for the increasing number of workers who have been entering the health care field in recent years. - - - Training programs are beginning to admit and attract new recruits in addition to the nurses and medical corpsmen with which many started. - - - Obstacles to the extensive participation of nonphysician workers in primary care exist, but can be removed if the need is great enough. - - - Meanwhile, existing physician and nurse licensure laws, with minor modification, can be used to protect and encourage further experimentation."

Following this report, the Committee named Robert J. Atwell, M.D., Frances E. Williamson and Monica V. Brown to study surveys conducted in Ohio and other states on this subject. An instrument was to be devised for use in Ohio with the target population being Ohio physicians — Doctors of Medicine and Doctors of Osteopathic Medicine.

In 1970, the Ohio State Medical Association conducted an "Opinion Survey" which included among its questions: "Do you favor the employment of trained 'physician assistants' to work in physicians' offices performing such tasks as, (a) preliminary screening for illness; (b) well-baby examinations; (c) family planning.

An excellent return of 5,400 replies was received on that survey, representing 55 percent of forms mailed.

Of those responding, 46 percent said "yes" and 54 percent "no" on (a); 39 percent "yes" and 61 percent "no" on (b); and 47 percent "yes" and 53 percent "no" on (c).

No other attempt has been made in Ohio to obtain additional and comprehensive information despite concern exhibited by all involved in planning for, delivery of and education for delivery of health care.

The final draft of the Ohio instrument was approved in May, 1972. The project was imple-

mented by Health Careers of Ohio with funds provided by Northeast Ohio Regional Medical Program; Ohio State Regional Medical Program; Ohio Valley Regional Medical Program and the Department of Health, State of Ohio. Endorsement was received from the Ohio State Medical Association, Ohio Osteopathic Association of Physicians and Surgeons, Ohio Hospital Association, Ohio Office of Comprehensive Health Planning, Department of Health, State of Ohio, Northeast Ohio Regional Medical Program, Ohio Valley Regional Medical Program, Northwest Ohio Regional Medical Program, Ohio State Regional Medical Program and Health Careers of Ohio.

American Medical Association

The American Medical Association has approved guidelines for the Assistant to the Primary Care Physician. Seventeen programs have been approved. National Certification of Physician's Assistants by Uniform Examinations is now under study.

Federal Support

As of October, 1972, more than \$6 million dollars in contracts and grants had been awarded to institutions in 26 states and the District of Columbia by the Bureau of Health Manpower Education, National Institutes of Health, Public Health Service, U.S. Department of Health, Education and Welfare.

Table I. House Calls and Physician Assistants

|   | %<br>YES | %<br>NO |
|---|----------|---------|
| 1. Could a trained assistant—                             |          |         |
| (a) replace you in any of your house calls . . . . .      | 18.5     | 38.9    |
| <input type="checkbox"/> DO NOT make house calls. (19.5%) |          |         |
| (b) help you in any of your house calls . . . . .         | 26.9     | 28.3    |
| (c) help in emergencies . . . . .                         | 58.9     | 15.3    |
| (d) help in minor surgery . . . .                         | 55.0     | 15.1    |

Table II. How Physician Assistants Would Affect Practice

|  |       |       |       |
|--|-------|-------|-------|
| 2. Please check how you feel greater use of trained non-physicians in your practice would affect —                     |       |       |       |
| (a) its quality <input type="checkbox"/> Increase <input type="checkbox"/> No change <input type="checkbox"/> Decrease | 28.4% | 40.3% | 15.2% |
| (b) its volume <input type="checkbox"/> Increase <input type="checkbox"/> No change <input type="checkbox"/> Decrease  | 52.9% | 27.2% | 3.5%  |

Table III. Possible Obstacles to Use of Nonphysician Personnel

|  |          |         |
|--|----------|---------|
| 3. Do you regard the following factors as major obstacles to greater uses of trained nonphysician personnel in medical practice? |          |         |
|  | %<br>YES | %<br>NO |
| Factors  |          |         |
| Shortage of trained workers . . .  | 53.6     | 24.9    |
| Patient non-acceptance . . . . .   | 43.7     | 36.5    |
| Impairment of Physician-Patient relationship . . . . .   | 42.5     | 37.8    |
| Higher cost . . . . .  | 33.8     | 45.2    |
| Excess time for supervision . . . .  | 35.9     | 42.2    |
| Legal and insurance problems . .   | 69.0     | 13.5    |
| Lack of office space . . . . .   | 29.4     | 48.4    |
| High worker turnover . . . . .   | 27.5     | 43.6    |

Table IV. Future Considerations Regarding Use of Nonphysician Personnel

|   |          |         |
|---|----------|---------|
| Would you consider interviewing, with a view to employing, the following graduates and persons with other specified training? |          |         |
|   | %<br>YES | %<br>NO |
| Graduates of —  |          |         |
| Four year programs . . . . .  | 40.3     | 33.0    |
| Three year programs . . . . .   | 35.5     | 35.5    |
| Two to three year programs . . .  | 34.0     | 37.6    |
| Two year programs . . . . .   | 30.4     | 41.1    |
| Other persons with specified training   |          |         |
| Persons with extensive on-the-job training . . . . .  | 41.4     | 30.3    |
| Allied health professionals and additional training . . . . .   | 39.6     | 30.4    |
| Registered nurses with additional training . . . . .  | 51.5     | 23.6    |
| Licensed practical nurses with additional training . . . . .  | 42.1     | 31.0    |

Legislation

Twenty-five states now have legislation of different types for physician assistants. These are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Iowa, Kansas, Maryland, Michigan, Montana, New Hampshire, New York, North Carolina, Oklahoma, Oregon, Utah, Vermont, Washington and West Virginia. In the absence of legislation, the role of physician assistants is determined by custom and usage.

Terminology

In discussion of the recognition of the physician assistant, and, in fact, with all of the health professions, much confusion exists regarding the definition of terms. Following is a glossary com-



piled by the Department of Health, Education and Welfare which defines various methods of acceptance.

**Accreditation** is the process by which an agency or an organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. Accreditation shall apply only to institutions and programs.

**Certification** is the process by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

**Licensure** is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or to use a particular title, or grants permission to institutions to perform specified functions.

**Registration** is the process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency.

**Qualifying examination** is a criterion for measuring an individual's ability to meet a predetermined standard.

**Equivalency testing** is the comprehensive evaluation of knowledge acquired through alternate learning experience as a substitute for established educational requirements.

**Challenge examination** is equivalency testing which leads to academic credit or advanced standing in lieu of course enrollment by candidate.

**Proficiency testing** assesses technical knowledge and skills related to the performance requirements of a specific job; such knowledge and skills may have been acquired through formal or informal means.

The survey was conducted by mail between July 15 and September 15, 1972. The number of questionnaires mailed (less those undeliverable and returned blank) was 12,908. Of that number, 3,472 responses were received, for a 27.0 percent return. Of Ohio's 88 counties, replies were received from 86, Vinton and Wyandot being the only counties from which no replies were received.

About two-thirds of replies were received from solo practitioners, and roughly one-third from physicians in group practice. Replies were received from physicians in 34 different fields of practice, indicating a cross section of Ohio physicians by type of practice as well as geographically. E.g., 988 replies were received from general practitioners, 333 from general surgeons, 404 from internists, etc.

Many of the respondents (38.9 percent) who make house calls indicated that physician assistants could not replace them on the house call, but the respondents were evenly divided on the subject of helping on house calls (See Table I). The majority (52.9 percent) of those responding felt that a physician assistant would increase the number of patients that a physician could see, and most (68.7 percent) indicated that the quality of medicine would either increase or not change (see Table II).

When questioned about possible obstacles, most respondents listed legal and insurance programs as the biggest obstacles (see Table III).

### Conclusions

In conclusion, the survey was productive in throwing light on current practices in the use of physician assistants in the broad sense of that term, but is clouded as to future practices.

It appears that Ohio physicians are about equally divided on the issues of employing physician assistants. With the possible exception of Registered Nurses, the respondents were split on employing graduates of ancillary medical personnel training programs (see Table IV).

Perhaps, if the legal and insurance questions are solved in the near future, and if training programs continue to grow as they do now, the use of nonphysicians as assistants will increase.



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1. Gertler, M. M., et al.: *Geriatrics* 25:134-148 (May) 1970.

**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

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**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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**Clinical Days on Emergency Care** — 80 hours of instruction on 20 separate days, September to June; Medical College of Ohio at Toledo, 945 S. Detroit Ave., Toledo 43614.

**Introductory Course in Nuclear Medicine for Physicians** — Nuclear Medicine Institute, 6760 Mayfield Rd., Cleveland 44124; five-day courses; dates upon request.

**Postgraduate Laparoscopy Courses** scheduled approximately every six weeks at Fairviw General Hospital, 18101 Lorain Ave., Cleveland 44111; for dates and details contact George P. Leicht, M.D., Chairman, Department of Ob-Gyn.

## April

**Ohio State University College of Medicine**, Continuing Medical Education Conferences; for details, contact OSU Center for Continuing Medical Education, 410 W. 10th Ave., Columbus 43210:

**Sex and Spinal Cord Injuries**, April 12-13

**Plastic Surgery in General Practice**, April 25

**Anesthesia**, April 27

**Myelomeningocele Conference**, April 28-29

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106;

**Current Topics in Clinical Microbiology**, April 4-5

**Peripheral Vascular Disease**, April 25-26

**Orthopaedic Surgery**, April 11-12

**Chronic Glomerular Disease: Clinical Pathological Correlations and Indications for Treatment**—Youngstown Hospital Association, South Unit, April 19; 8:00 a.m.; Dr. Robert S. Post, associate professor of medicine, Case Western Reserve University.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

**Clinical and Laboratory Estimation of Renal Function**—Youngstown Hospital Association, South Unit, April 23, 4:00 p.m.; Medical Seminar; Drs. R. A. Bacani and Y. O. Sheth.

**Twenty Years' Experience with Renal Transplantation — Biological Dividends and Future Possibilities** — by Dr. Joseph E. Murray, internationally recognized professor of surgery at the Peter Bent Brigham Hospital, and visiting professor in the Department of Surgery, Division of Plastic Surgery, Ohio State University; 1:00 p.m., April 23 in Room 160, East Auditorium of the OSU Medical Administration Bldg., College of Medicine; also, **The Analysis and Treatment of Craniofacial Anomalies**, on April 24, same time and place. Contact Ronald B. Berggren, M.D., Director, Division of Plastic Surgery, 410 West 10th Ave., Columbus 43210.

**Genetics in Clinical Practice** — At the Marriott Inn, 2124 S. Hamilton Ave., Columbus, April 24-25; sponsored by Division of Maternal and Child Health, Ohio Department of Health, and Dept. of Pediatrics, Children's Hospital, Columbus; guest speakers, Dr. Howard Pearson, Yale University; Dr. David Smith, University of Washington; and Dr. Henry Nadler, Children's Memorial Hospital, Chicago. Contact, Stella B. Kontras, M.D., Children's Hospital, Columbus 43205; phone 614/253-8841, ext. 254.

**Buckeye Anesthesia Study Society**, first scientific dinner meeting, April 25, at the Imperial House South, I-75 at the Miamisburg-Centerville exit, Dayton; cocktails 6:00 p.m., dinner at 7:00 and speaker at 8:00 p.m.; speaker, N. W. Brian



## Educational Opportunities in Ohio — *Continued*

Craythorne, M.D., chairman, Dept. of Anesthesia, University of Cincinnati; contact, Martin L. Norton, M.D., Secretary, Miami Valley Hospital, 1 Wyoming St., Dayton 45409.

**Sixth Annual Diabetes Seminar** — Sponsored by Akron City Hospital, at the Isabelle Firestone Nursing Auditorium, 41 Arch St., April 25; 8:00 a.m. Thomas R. Riley, M.D., coordinator.

**Orthopaedic Surgery** — Akron City Hospital, 525 E. Market St., Akron; April 27; 8:00 a.m.; Visiting Professor program, featuring Dr. Ferrer-Torres, from Madrid, Spain.

**Family Relations Workshop**—April 27-29 at Salt Fork Lodge, Cambridge; sponsored by Ohio Academy of Family Physicians.

### May

**University of Cincinnati College of Medicine (CONMED)**—Eden and Bethesda Avenues, Cincinnati 45219:

**Velo-Pharyngeal Insufficiency**, May 3

**General Surgery**, May 16-17

**Internal Medicine—Current Concepts of Clinical Problems**—Cosponsored by the American College of Physicians, May 21-25

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106:

**Organization and Administration in Anesthesiology**, May 5-6

**Advances in Dermatology**, May 9-10

**Newborn Conference**—Ohio State University College of Medicine, May 2-3, at the Center for Tomorrow; contact OSU Center for Continuing Medical Education, 410 W. Tenth Ave., Columbus 43210.

**Obstetrics and Gynecology** — Akron City Hospital Visiting Professor program, with William E. Copeland, M.D., Ohio State University; 525 Market St., Akron, May 3-4; 8:30 both mornings.

**Gynecologic Endoscopy** — St. Luke's Hospital, 11311 Shaker Blvd., Cleveland 44104; May 2-3; and **Recent Advances in Reproductive Physiology**, May 4; contact Amir H. Ansari, M.D., at the hospital, phone 216/791-1000, ext. 360.

**Cytogenetics, Noting Prenatal Diagnosis, Clinical Consideration and Counselling**—Sponsored by the Cleveland Society of Obstetricians and Gynecologists at the Marriott Inn, 4277 West 150th St., Cleveland, May 9, educational forum starting at 3:00 p.m.; Cecil Jacobsen, M.D., and Neil Mc-

Intyre, M.D., guest speakers; dinner and evening meeting, 7:00 p.m., **Recent Advances in Reproductive Genetics** by Dr. Jacobsen. Contact, Kathryn E. Hoffman, M.D., 2060 E 9th St., Cleveland 44115.

**Cardiology Highlights** — Akron City Hospital, 525 Market St., May 9, 9:00 a.m.; Thomas R. Riley, M.D., Coordinator.

**Endoscopy and Gastrointestinal Bleeding**—Youngstown Hospital Association, South Unit, May 17, 8:00 a.m.; Dr. Reed T. Keller, of Case Western Reserve University, guest lecturer.

**Research in Esophageal Repair**—Veterans Administration Center, 4100 W. Third Street, Dayton 45428; May 18; 2:30 p.m.; Dr. Charles L. Cogbill; **A New Approach in the Treatment of Esophageal Perforation**, Dr. Krishna V. S. Rao; **A New Treatment for Esophageal Stricture**, Dr. Mahood Mir.

**Internal Medicine, Current Concepts of Clinical Problems**—Sponsored by the American College of Physicians and the University of Cincinnati College of Medicine; May 21-25 at the Medical Center, Cincinnati.

**Visiting Professor Program** — Akron City Hospital, 525 Market St., May 22; visiting professor, William C. Roberts, M.D., chief, Section on Pathology, National Heart and Lung Institute.

**General Surgery** — Akron City Hospital, 525 Market St., May 24-25; visiting professor, Theodore Drapanas, M.D., Department of Surgery, Tulane University School of Medicine.

**Digitalis and Injured Heart**—Youngstown Hospital Association, South Unit, May 28, 4:00 p.m.; Drs. W. H. Bunn, Jr., and R. D. Arnott.

**Refresher Course in Diagnostic Roentgenology, 15th Annual** — Radiology Dept., University of Cincinnati College of Medicine, under direction of Benjamin Felson, M.D., May 29 - June 2; for radiologists and radiology residents; contact Dr. Harold B. Spitz, Dept. of Radiology, Cincinnati General Hospital, Cincinnati 45229.

### June

**Visiting Professor Program** — Akron City Hospital, 525 Market St., June 14-15; Beverley T. Mead, M.D., chairman, Department of Psychiatry, Creighton University School of Medicine.

# St. Elizabeth Hospital, Youngstown, Announces Continuing Education Courses

## April

Dept. of OB-Gyn Visiting Professor Series: Current Concepts in OB Anesthesia, Carl Redderson, M.D., April 5; Impact of Venereal Disease in OB-Gyn, Delbert Booher, M.D., April 12; Premalignant and Malignant Lesions of Vulva and Vagina, W. B. Wentz, M.D., April 19; Treatment of Uterine Cancer — Cervix and Corpus, Dr. Wentz, April 26.

Department of Surgery Grand Rounds: Diabetic Gangrene, Demetrios J. Dallis, M.D., April 5; Venous Diseases of the Lower Extremities, Robert Hritz, M.D., April 12; Zollinger - Ellison Syndrome, Rashid Abdu, M.D., April 19; Shock, Felix Pesa, M.D., April 26.

Family Practice: Most Common Endocrine Disturbances, Exclusive of Diabetes and Thyroid Disease, Dr. W. Cleary, April 6; Management of Coronary Occlusion, Dr. L. Caccamo, April 13; Stroke and Rehabilitation, Dr. Gilliland, April 20; Diuretics and Their Uses, Dr. E. Kessler, April 27.

Dept. of Pediatrics and CORE Conferences: Immunization, Kurt Wegner, M.D., April 4; Poisoning in Children, Dr. Wegner, April 18.

The Clinical Examination: Leads, L. P. Caccamo, M.D., April 11; Anatomical (X-Ray) and Electrical (ECG) Positions of the Heart, Dr. Caccamo, April 25.

Dept. of Medicine Hematology Conferences: Pancytopenia with a Hypercellular Marrow of Undetermined Etiology, Dr. Jensen, April 9; Leukemoid Reaction, Dr. Westerman, April 23.

Dept. of Medicine Grand Rounds: Liver Cirrhosis, Dr. Tiberio, April 10; Hypercalcemia, Dr. Cleary, April 17; Audit Conference, Dr. Saadi, April 24.

Dept. of Medicine Visiting Professor Series: Workup of Acute Arthritis, Thomas A. Medsger, M.D., April 12; Rheumatic Heart Disease with Mitral Valve Disease, James J. Leonard, M.D., April 26.

Dept. of Medicine G. I. Conferences: G. I. Bleeding, Dr. Gaylord, April 17; Steatorrhea, Dr. Gregori, April 24.

Dept. of Medicine Endocrinology Conferences: Aldosteronism, Dr. Jung, April 7; Turner's Syndrome, Dr. Jung, April 14; Acromegaly, Dr. Jung, April 21; Granulopharyngioma with Hypopituitarism, Dr. Jung, April 28.

Tumor Conference (Medicine): Adenocarcinoma, George River, M.D., April 5; Stage IV Serous Cystadenoma of Ovaries, Osteogenic Sarcoma Left Distal Femur, Ulcerating Carcinoma of Stomach, Stage IV Breast Carcinoma, Dr. River, April 12; Myeloblastic Leukemia, Cancer of Breast, Colon, Head of Pancreas, Dr. River, April 19; Metastatic Ca (Primary?), Ca of Stomach, Myelofibrosis, Urinary Bladder Ca, Dr. Riber, April 26.

Dept. of Anesthesia: The Endocrines and Anesthesia, Dr. Lee, April 5; The Autonomic Nervous System, Dr. Dziadzka, April 12; Hyperthermia and Hypothermia, Dr. Richards, April 19; Obstetrical Anesthesia, Dr. Malta, April 26.

## Nation's Medical Historians to Meet in Cincinnati, May 3-5

Following is the text of a letter addressed to members of the Ohio Academy of Medical History and signed by Emanuel D. Rudolph, Ph.D., Secretary-Treasurer.

"This year the Ohio Academy of Medical History, as a result of a vote taken last year at the annual meeting, will ask its members to accept the invitation of the American Association for the History of Medicine to attend its annual meeting to be held in Cincinnati May 3-5, 1973. The executive committee of the Ohio Academy of Medical History decided that having our own annual meeting during, or after, the national association's would be redundant. Thus, we plan to skip our annual meeting this year. We hope that this will mean that next year will be a bumper

year for contributed papers at our meeting. We look forward to that.

"We are pleased to have the national association meet in Ohio and trust that many of our members will attend. You will soon receive a copy of the program together with information about registration and housing. We can help to make the visiting historians of medicine welcome to Ohio. Some of our members are already much involved in the planning of the meeting. It should be a gala occasion. Plan to attend!

"If you have not paid your annual dues of \$1.00 or have done so with a joint membership in the Ohio Historical Society, they are now welcome. See you in Cincinnati in May."

Physicians interested in medical history as well as members of the Academy are invited to contact Dr. Rudolph at the Department of Botany, Ohio State University, 1735 Neil Ave., Columbus 43210.

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# GUIDELINES

## for Establishing and Operating Multiphasic Health Testing Programs

AT THE REGULAR MEETING of The Council of the Ohio State Medical Association on January 27-28, the following set of "Guidelines for Establishing and Operating Multiphasic Health Testing Programs" was accepted as the official policy of the Association. The guidelines were developed by the OSMA Committee on Judicial and Professional Relations.

\* \* \*

1. "Multiphasic health testing" (MHT) is defined as a method of acquiring, storing, collating and reproducing medical data on individual patients. N.B.: MHT is not in and of itself a complete health service or a complete health or physical examination: MHT procedures comprise only part of the physical examination of the patient conducted by the physician and shall be performed only upon request or order of the patient's physician for his use as an aid in continuing patient examination and care. MHT procedures must be limited to fact-finding and exclude interpretation. Findings disclosed by MHT procedures should be interpreted only by physicians.

2. The practicing physician may recommend MHT procedures where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of MHT facilities and not adopt the practice of routinely requiring that all patients or all new patients undergo such testings.

An attending physician may not receive a rebate, referral fee, commission or the like from a program whose facilities have been used by his patients.

3. Any MHT facility operating in Ohio shall conform to all applicable federal, state and local laws and regulations and each facility shall maintain its own quality control and quality control records.

4. Physicians must be involved in the planning, development and evaluation of MHT facilities and programs.

5. The operation of any MHT facility and program shall be supervised by a duly licensed and qualified physician or physicians at the testing facility. Testing facilities should preferably be located in hospitals.

6. Any MHT program should be designed to make maximum use of allied health professionals and to utilize technical and automated techniques where justified.

7. For professional and economic feasibility, all MHT programs should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable levels of sensitivity, specificity, high predictive value, and patient acceptance. Tests which are complicated, involve risk to the patient and are more difficult to interpret may be included in the program only if adequate physician supervision is available and utilized to insure both quality control and adequate patient care.

8. All MHT programs should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs.

9. All MHT programs shall provide for and maintain the confidentiality of patient data.

10. It is not, in and of itself, unethical for a **physician to own** a MHT facility or an interest therein. The use the physician makes of this ownership or interest may, however, be unethical.

11. Solicitation directly or indirectly by MHT systems shall be unethical.

12. A **physician employed** by a MHT facility should not, in conformity with the well-established policy of the Ohio State Medical Association, (a) dispose of his professional attainments to **any** corporation or lay body under terms or conditions which permit the sale of the services of that physician by such corporation or lay body for a fee, or (b) allow his name or the prestige of his professional status as a physician to be used in the promotion of any commercial enterprise. The physician should neither aid nor abet an unlicensed individual or corporation to practice medicine.

13. The Council of the Ohio State Medical Association is ready to assist in answering and should be consulted regarding any ethical questions regarding the planning, development and operation of a MHT facility and program.

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# Obituaries

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**Floyd Pierpont Allen, M.D.**, Cincinnati; University of Michigan Medical School, 1921; aged 81; died February 14; member of OSMA and AMA; former director of research for the Public Health Federation in Cincinnati from 1929 to 1956, and former assistant professor of preventive medicine at the University of Cincinnati.

**Jerry E. Arrington, M.D.**, Columbus; University of Tennessee College of Medicine, 1932; aged 64; died February 15; member of OSMA, AMA, and the American Academy of Ophthalmology and Otolaryngology; diplomate, American Board of Otolaryngology; practitioner of long standing in Columbus, specializing in ophthalmology and otolaryngology.

**Walter Michael Barth, M.D.**, Westlake and Cleveland; St. Louis University School of Medicine, 1942; aged 55; died February 2; member of OSMA and AMA; Fellow, American College of Obstetricians and Gynecologists; practicing physician in the Cleveland area for a number of years, specializing in obstetrics and gynecology; veteran of World War II.

**Robert John Becksted, M.D.**, Cleveland; Western Reserve University School of Medicine, 1946; aged 50; died February 15; former member of OSMA; practitioner in Dayton for a number of years and in recent years in the Parma area of Greater Cleveland; served in the Air Force Medical Corps during the Korean Conflict.

**Russel D. Bussdicker, M.D.**, Duarte, Calif.; Ohio State University College of Medicine, 1917; aged 81; died February 5; medical missionary in Iran for 37 years; veteran of World War I.

**Ernest William Campbell, M.D.**, Moraga, Calif.; University of Pittsburgh School of Medicine, 1907; aged 91; died January 6; former member of OSMA and AMA; practitioner from 1924 to 1957 in Toledo where he specialized in the EENT field.

**Gordon Lee Gudakunst, M.D.**, Columbus; Ohio State University College of Medicine, 1961; aged 37; died January 28; resident in psychiatry, associated with the Columbus Area Mental Health Center.

**Estes J. Gunn, M.D.**, Cleveland; Meharry Medical College School of Medicine, 1919; aged 80; died January 29; former member of OSMA and the AMA; member, American Academy of Family Physicians, and the National Medical Association; general practitioner of long standing in Cleveland and recipient of the OSMA 50-Year Award; veteran of World War I.

**Adolf Haas, M.D.**, Columbus; medical degree from the University of Marburg/Lahn, West German, 1951; aged 52; died February 18; member of OSMA, AMA, and American Psychiatric Association; diplomate, American Board of Psychiatry and Neurology; practitioner in Columbus for a number of years, specializing in psychiatry.

**Edith Wallace Hammill, M.D.**, Cleveland; Ohio State University College of Medicine, 1928; aged 72; died January 28; member of OSMA and AMA; general practitioner in Cleveland before her retirement in 1967. Her husband, Dr. Gordon H. Hammill was killed in action during World War II. Among survivors is a physician son, Dr. William A. Hammill, of Spartanburg, S.C.

**Joseph B. Klein, M.D.**, North Canton; University of Louisville School of Medicine, 1931; aged 68; died February 6; member of OSMA, AMA, American Academy of Dermatology, and American Academy of Facial, Plastic and Reconstructive Surgery; diplomate, American Board of Dermatology; practicing dermatologist in the Canton area for 27 years; veteran of World War II.

**Sydney Levin, M.D.**, Cleveland; University of Cincinnati College of Medicine, 1922; aged 74; died February 10; former member of OSMA; private practitioner in Cleveland until about 25 years ago when he joined the Veterans Administration and moved first to California and later to Michigan; retired about five years ago and returned to Cleveland.

**Henry Andrew Long, Jr., M.D.**, Dayton; Meharry Medical College School of Medicine, 1962; aged 42; died February 4 of a gunshot wound; former member of OSMA and AMA; practitioner for about ten years in Dayton.



**Joseph John McHugh, M.D.**, Ottawa, Ohio; Jefferson Medical College of Philadelphia, 1943; aged 55; died February 4; member of OSMA; practitioner in the Ottawa area since 1949 and Putnam County health commissioner since 1971; veteran of World War II.

**Elizabeth Ann Leggett McKee, M.D.**, La-Guna Hills, Calif.; University of Minnesota Medical School, 1928; aged 74; died July 31; former member of OSMA; member, American Thoracic Society; Fellow, American College of Chest Physicians; physician at Kent State University until 1949 when she moved to California. Her husband died about a year ago.

**Peter James McOwen, M.D.**, Tustin, Calif.; Dalhousie University Faculty of Medicine, Canada, 1926; aged 75; died February 10; member of OSMA, AMA, and American Academy of Dermatology; moved to California in 1970 after practicing since 1929 in Youngstown where he specialized in dermatology; formerly associated in practice with his son, Dr. Peter J. McOwen, Jr., Youngstown, who is among survivors.

**Alva Justin Payne, M.D.**, Ironton; Ohio State University College of Medicine, 1935; aged 64; died January 18; member of OSMA and AMA; practitioner in Lawrence County since 1936. Two sons are professional men, A. Burton Payne, M.D., and William P. Payne, D.D.S., both of Ironton.

**Roger Edmund Pinkerton, M.D.**, Akron; University of Illinois College of Medicine, 1923; aged 77; died February 12; member of OSMA, AMA, American Psychiatric Association, and Cen-

tral Neuropsychiatric Association; practitioner of long standing in Akron, specializing in psychiatry and neurology. Among professional men in the family are sons, Dr. Donald R. Pinkerton and Dr. Burnel Pinkerton, and brothers, Dr. Charles P. Pinkerton and Dr. John Pinkerton.

**Arlington Joseph Rawers, M.D.**, Celina; Ohio State University College of Medicine, 1924; aged 74; died January 23; former member of OSMA; practitioner of long standing in the Celina area; former health commissioner of Mercer and Auglaize Counties; former secretary of the Mercer County Medical Society.

**Leo Rosenberg, M.D.**, Dayton; Tufts University School of Medicine, 1924; aged 72; died January 31; member of OSMA, AMA, American Rheumatism Society, and American Academy of Physical Medicine and Rehabilitation; diplomate, American Board of Physical Medicine and Rehabilitation; associated for some 20 years with the rehabilitation service at the Veterans Administration Hospital in Dayton; also associated with Good Samaritan Hospital, and a private practitioner recently in Dayton; clinical associate professor, OSU College of Medicine; active duty during World War II and retired captain in the Navy Reserve.

**Henry A. Schlink, M.D.**, Cleveland; University of Michigan Medical School, 1913; aged 81; died January 29; member of OSMA and AMA; practitioner of long standing in Cleveland; veteran of World War I, during which he served in the Army Medical Corps; associated in practice with his brother Dr. Albert G. Schlink who survives.

*(Continued on Next Page)*



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John Warren Stack, M.D., Mesquite, Texas; University of Cincinnati College of Medicine, 1947; aged 48; died January 29; practitioner in the Mesquite area since 1948. A former resident of Athens County, he was a grandson of the late Dr. Warren Sprague.

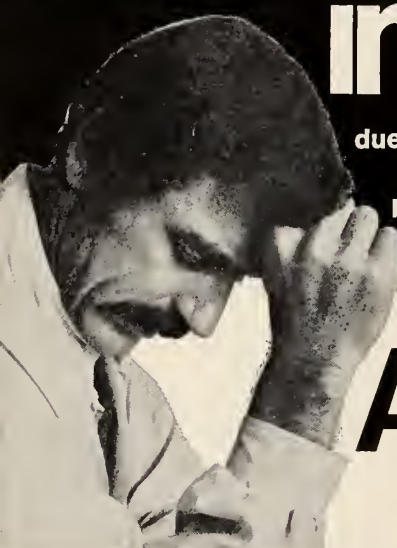
Charles Frederick Thompson, M.D., Caldwell; Ohio State University College of Medicine, 1929; aged 71; died January 15; former member of OSMA and AMA; practitioner of long standing in Noble County; former member of the Noble County Health Department; past president of the Noble County Medical Society.

Louis Alfred Vogel, M.D., Euclid; St. Louis University School of Medicine, 1932; aged 66; died January 25; member of OSMA, AMA, and American Academy of Family Physicians; General practitioner of long standing in the Euclid area; veteran of World War II. Among survivors is a son, Dr. Donald Vogel who was associated with his father in practice.

Bert McKinley Warne, M.D., Ft. Lauderdale, Fla.; Eclectic Medical College, Cincinnati, 1920; aged 79; died January 21; former member of OSMA and AMA; retired some years ago after practicing in the Cincinnati area where he specialized in radiology.

Cyrus Rogers Wood, M.D., Port Clinton; University of Louisville School of Medicine, 1929; aged 70; died February 11; member of OSMA and AMA; practitioner in the Port Clinton-Toledo area since 1930; served as Ottawa County health commissioner for 20 years; served in the Army Medical Corps during World War II.

Wendell Irving Zaring, M.D., Kenton; Indiana University School of Medicine, 1954; aged 46; died January 22; member of OSMA, AMA, American Society of Anesthesiologists, and the International Anesthesia Research Society; practitioner in Hardin County since 1956 specializing in anesthesiology.



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Fertility and Sterility, January 1970  
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**Hypercalcemia** may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

**References:** 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12 69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5 67, 1964. 3. Telford, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25 6, 1962. 4. Hellman, L., Bradlow, M. L., Zimoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androstereone. J Clin Endocr 19 936, 1959. 5. Farns, E. J., and Colton, S. W. Effects of L-thyroxine and l-thyroxine on spermatogenesis. J Urol 79 863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 28). Lippincott, Philadelphia, 1959, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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*"The history of science, and in particular the history of medicine... is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."*

*—George Sarton, from "The History of Medicine Versus the History of Art"*

**Are there significant  
differences in bioavailability  
and clinical predictability  
among drug products?**

**Opinion**

**Results of a questionnaire to  
7,000 physicians:**

**44.6%**

**Agree there is a significant  
difference**

**24.9%**

**Believe there is no difference**

**30.5%**

**Had no opinion**



## Are there significant differences in bioavailability and clinical predictability among drug products?

### Teacher of Medicine

Alfred Gilman, Ph.D.  
Wm. S. Lasdon  
Professor & Chairman  
Department of  
Pharmacology  
Albert Einstein  
College of Medicine of  
Yeshiva University



I think that there can be a very great distinction between generic drugs and brand name drugs. And that applies to products of original research that have outlived their patent protection as well as to drugs that have long been in the public domain. Let me explain why.

#### The Importance of the Manufacturing Environment

In terms of formulation, quality control, and the ability to reproduce an essentially identical product, batch after batch, I doubt that many firms are properly equipped to put out a product that is as carefully controlled as the product marketed by a pharmaceutical company with sophisticated research and high quality manufacturing facilities. For example, when a company comes out with its own preparation of a drug that has just lost its patent protection, there is no assurance that the drug it produces will be a therapeutic equivalent. The raw material could be identical and yet bioavailability might vary from complete unavailability to that which is equivalent to the original.

#### It Isn't Enough to Meet USP and NF Standards

Meeting USP and NF standards is not enough to guarantee therapeutic equivalence. In certain instances, stricter standards must be applied. Right now, the New York Heart Association has a committee that is studying the problem of digoxin equivalent

lency. I am certain that they are going to recommend a bioavailability assay of a particular digoxin. Unless this is done, they will not recommend it for purchase or use in New York City hospitals. It represents too much of a hazard. They have gone so far as to recommend a batch-by-batch certification of bioavailability even though the company has been reproducing and marketing a digoxin product through the years.

#### The Problem of Controlling Bioavailability of Generics

The FDA does not have the manpower to inspect the quality control capabilities of hundreds of houses specializing in generic products. And I don't think that the average pharmacist is knowledgeable or aware of the quality and bioavailability of the infinite numbers of generic preparations. A recommendation has been made that every time a generic house (or for that matter a large pharmaceutical company) markets an already existing drug for the first time, a modified new drug application should be submitted. The manufacturer would have to show that his compound is the therapeutic equivalent of the standard compound in use, assuming that the standard compound is one that has been available for an extended period—say 15 years. This would be one indication that the control of bioavailability is beginning to get the attention that it deserves.

#### Clinical Predictability More Important Than Price

Although the question of price has been greatly exaggerated, it is true that patients can on occasion save money on generic drugs. But you are not going to dare attempt to save money if it jeopardizes the patient's health. Let's return to the example that has become very prominent in recent years, that of the cardiac glycosides. They are probably the most toxic drugs we use with respect to the small difference between a maximally effective dose and a toxic dose. When you are dealing with drugs of this type, the first concern must be clinical predictability. At the risk of variations in bioavailability, it would be sheer folly to try to save the patient what might amount to maybe \$10 or \$20 a year. The physician cannot manage his patient unless he is sure that the drug he is prescribing has the same positive effect each time the prescription is renewed. This is especially significant when the patient takes the product, not for months, but for the rest of his life.

# Maker of Medicine

C. J. Cavallito, Ph.D.  
Executive Vice President  
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minimize nonequivalence of drug components produced by different manufacturers. Arguments relate largely to the extent of product inequivalences. Experience over the past six years has uncovered a greater incidence of nonequivalence of products prepared by different manufacturers from generically equivalent substances than many had previously surmised.

### Newer Bioavailability Studies Reveal Differences

Bioavailability may be defined as a measure of the rate and amount of absorption of a drug substance from its administered dosage form. For several years pharmaceutical scientists have proposed that bioavailability data on presumably equivalent dosage forms provide the best measure of product equivalence—short of adequate clinical trial. In their continued search for shortcuts to the evaluation of product equivalence, medical and pharmaceutical scientists have increasingly relied upon bioavailability characteristics as reflected by blood levels of a drug after its administration to human subjects.

Leading manufacturers now conduct comparative bioavailability studies on their own product dosage forms after production process changes that would have been considered inconsequential a few years ago. This isn't surprising, since there are so many possible differences in production operations that the opportunities for inequiva-

lent generic and brand name products are numerous—even when the production process begins with identical chemical substances. Moreover, reputable manufacturers are striving to improve *in vitro* control measures, such as dissolution characteristics, which are being related more meaningfully to bioavailability reference data.

As a result of advances in scientific instrumentation and analytical methodology which permit measurements of small quantities of drug substances in the body, our abilities to detect differences in bioavailability and possible therapeutic nonequivalence have appreciably improved.

### Product Selection Based on Patient Response

Improved specifications and standards can better assure the equivalence of *drug substances*. Manufacturers, compendia and regulatory agencies can all play a part. However, it is the *drug product*, not the *drug substance*, that the physician, pharmacist, nurse and patient-customer utilize. How can these indi-

viduals make or influence specific product selections to minimize variations in therapeutic equivalence of multisource drugs? Patients' responses to a drug product provide a basis of experience to aid the physician in his selection of a particular product. The nurse and pharmacist can also help detect patient responses, but ultimate responsibility must remain with the physician.

### Reputation of Manufacturer as Basis for Product Selection

The physician, to assure that his patients receive quality health care, must rely upon the capabilities of the reputable pharmaceutical manufacturer who is equipped to develop, prepare and control a quality product of uniform, reliable therapeutic performance. Substitution with purportedly equivalent generic products that are only superficially evaluated by an imitator manufacturer can place the health of the patient secondary to factors of price or convenience for the provider.

Although equivalence of different preparations of a *drug substance* may be defined by certain physical, chemical or biological characteristics, identity is not always assured even though these characteristics may be described in compendia such as the USP, NF or defined by other specific source standards. Moreover, even with equivalent *drug substances*, similar *pharmaceutical products* can be produced by different manufacturers such that these products are biologically or therapeutically inequivalent.

### A Growing Awareness of Potential for Nonequivalence

As experience increases with drug substances derived from different sources and under different conditions, it should be possible to establish specifications in sufficient detail to minimize the potential for their nonequivalence. However, there is general agreement that product therapeutic equivalence would still not be assured even if one could

# Opinion & Dialogue

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## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, blurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient dizziness or ataxia may occur.

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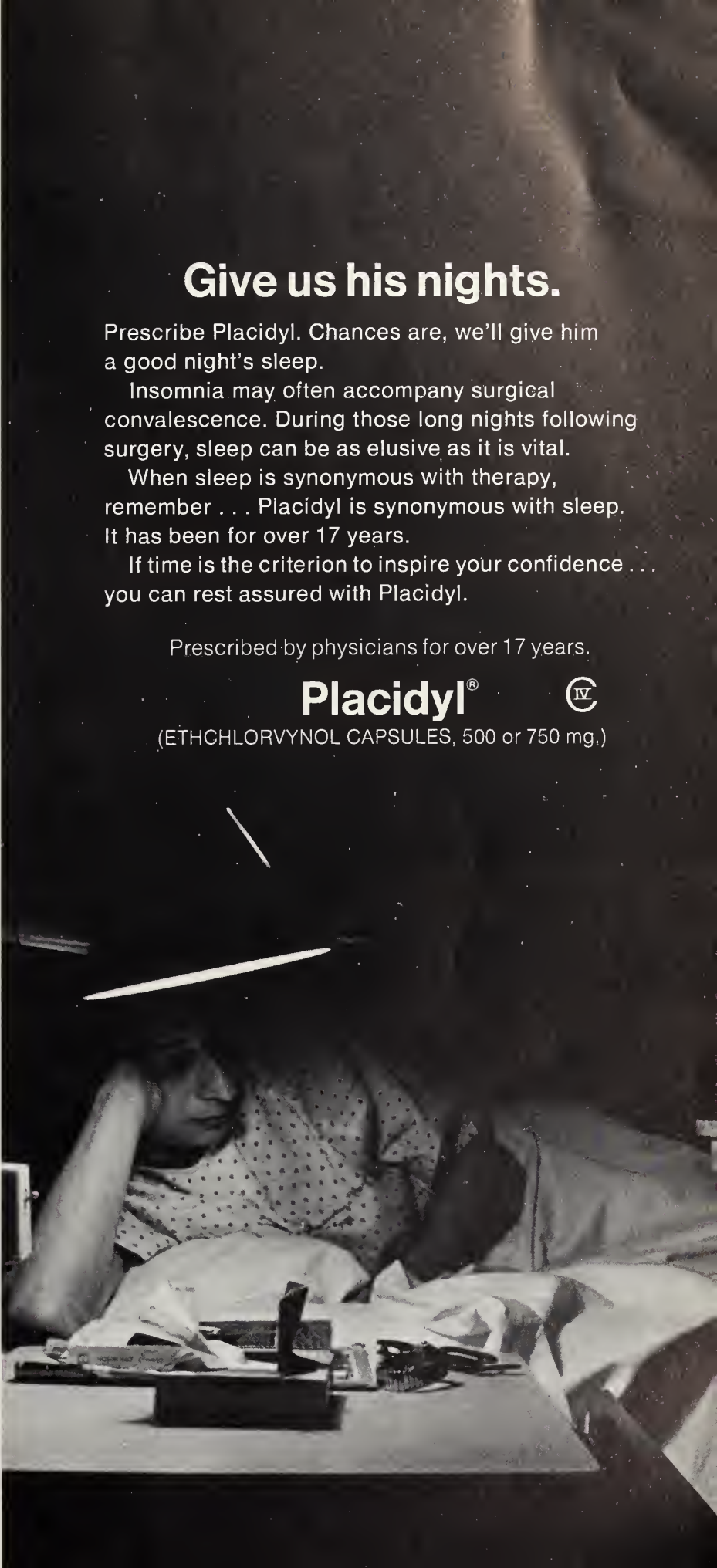
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## Changing Concepts in Academic Medicine

JAMES CERILLI, M.D.

**M**OST PHYSICIANS are familiar with the history of the development of medical science and the discoveries which have contributed to medical knowledge. However, the concept of medical education and academic medicine has also advanced and changed during the past centuries, but its objective of providing adequate and constantly improving medical care for the people has remained the same. For many centuries, academic medicine and the education of doctors of the future centered around an individual: the clinical practitioner. Grouped around him were one or two aspiring physicians who, simply by constant observation, became familiar with the role of the physician and with the medical knowledge he employed in treating his patients. The aspiring physician was nothing more than an apprentice; he was not a student. There was no formal structure to his education, and research was completely nonexistent.

### European Medical Education

The first association of medical education with the university took place in Bologna, Italy, in the Middle Ages.<sup>1</sup> There was a small medical

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faculty, again consisting primarily of practitioners clustered within the university, who delivered a few lectures and conducted some anatomical dissections. Known as the Student Master, the faculty member held a highly respected position, which exceeded that of the Cardinal of the Church. However, his responsibilities to his students were indeed great. It was a firm rule that the teacher could not be absent without the students' permission, and the instructors were required to take an oath of obedience to the students. The professors had no fixed salaries at this time, and they were paid for their instruction by the students, with the result that some popular teachers were able to amass great fortunes from their fees. Later, the City of Bologna paid the salaries of all teachers to eliminate the necessity of student popularity for financial stability.

Medical education changed very little for one or two centuries, while the science of medicine advanced greatly with the stimulus of such people as Leonardo DaVinci, Ambrose Paré, and many

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Submitted July 31, 1972.



others.<sup>1</sup> The center for medical knowledge gradually shifted from Italy to England and France, but the system of education remained basically the same. In 1518, the Royal College of Physicians was founded in England in an attempt to examine and license physicians and thus guarantee the public the adequacy of their medical knowledge. Medical and surgical knowledge at this time was still extremely primitive, as evidenced by the rule that "surgeons should not barber and barbers could not practice surgery." In the year 1535, a private company was founded called the Company of Barbers and Surgeons which, by means of a very limited curriculum, attempted to teach the clinical practice of surgery.

The medical schools of the late 18th and early 19th centuries in England and France were almost exclusively the clinical type. The student learned anatomy outside the hospital from a practicing physician and followed him through the hospital wards as an apprentice. He was solely an apprentice, and still not yet a student. Nevertheless, this era produced some outstanding physicians and investigators, such as Claude Bernard and Louis Pasteur. However, there was a lack of interest on the part of the medical schools and the governments to provide adequate research facilities; Bernard worked in a wine cellar and Pasteur, in his attic. It was this failure of the medical schools to assume the role of scientific investigation that led to the decline of French and English medicine around 1850 and to the rise of the excellence of medicine as practiced in Germany, Holland, and the Scandinavian countries. In these countries, medical education became very intimately linked with the universities and the teachers held university rank of professor of medicine. In addition, laboratory support was provided to the medical educator, and his research was expected of him as much as his teaching.<sup>2</sup> Within a very brief period, medical science advanced greatly in Germany because, for the first time, academic medicine had assumed a new role: that of active investigation or formalized research. However, as judged by the current definition of a student, the young doctor in training remained an apprentice; formal curriculum was scanty; lectures remained sporadic; and uniform standards were never applied.

### Preceptorships and Proprietary Schools

The teaching of medicine and medical practice in the American Colonies in the early 1700's was understandably influenced by the English and French systems more than by the Germanic. Young men wishing to be doctors were taken in as apprentices by older established physicians who had been trained in the European schools. They learned

simply by watching their preceptors treat patients. This method temporarily filled the need for doctors in this country, and when a doctor finished his apprenticeship, his preceptor issued him a "license" to practice medicine.

Formal medical education did not begin in the United States until 1765, with the founding of the College of Philadelphia,<sup>3</sup> later the University of Pennsylvania Medical School, by John Morgan and William Shippen. The College of Philadelphia was the first to attempt to bring together in a formal university structure the teaching of academic medicine in the United States. It awarded the first medical diploma in this country in 1768, just slightly over 200 years ago. Although the second medical school, the Medical School of King's College of the City of New York, was founded in 1768, the teaching of medical students and the application of research technics in this country remained extremely haphazard. Medical leadership continued to reside in Germany, Great Britain, and France, and with their stimulus, the lecture system was incorporated into the medical schools of this country. In the late 1700's and early 1800's, a large number of proprietary schools developed within this country. Small groups of physicians banded together and called themselves medical faculties. They were able to obtain charters from state legislatures which gave them the right to conduct medical training and grant degrees. The proprietary schools had no entrance requirements, the course was limited to about ten weeks, and the schools usually consisted of one lecture room and a few books that were loosely called a library. Within a very short time, over 400 of these proprietary schools came into existence, turning loose on the public large numbers of individuals who were legally able to call themselves physicians but had no foundation in the medical sciences. In the early 1800's, less than 10 percent of the physicians in the United States were graduates of the few medical schools, and more than 80 percent of the physicians had never even attended a lecture.

During this period, there were no activities on the part of the few medical schools in the area of research. With the exception of participation in charity clinical care, there were no activities in the area of social medical reform. Academic medicine was indeed in a state of chaos in this country little more than 125 years ago. In 1848, the recently established American Medical Association organized a Committee on Medical Education which suggested that a formal curriculum be established in medical schools, that a high school education be necessary for admission into medical school, and that licensure be separated from education. Some of these suggestions were adopted by such schools as Northwestern University in 1859, which instituted a graded and formal curriculum.

## Organized Academic Medicine

There is little doubt that the greatest impetus to improved medical education and organization of academic medicine within this country came from the founding of Johns Hopkins University Medical School in 1892. With an endowment of \$7 million, a medical school was organized by Doctors Welch, Kelley, Halsted, and Osler, with an extremely close university affiliation. A full-time salaried faculty was appointed; for the first time students were required to have an undergraduate degree; a formal structured curriculum was instituted; and women were even admitted to medical school for the first time. With the institution of the full-time system of medicine and the requirement of undergraduate education, a prospective physician became a true student. The full-time system provided for organization and participation in research activities by the faculty which more closely approximated the research carried on in the continental schools of medicine. By the early 1900's, the adequacy of medical care in this country under the guidance of medical schools was being met through a three-pronged system of student education, research, and clinical practice within the hospitals. The organization of the Hopkins system stressed the need for the combination of these three activities within a formal university structure.

In spite of the leadership provided by Johns Hopkins, the proprietary school system died a very slow death. In the early 1900's, the American Medical Association asked the Carnegie Institute to undertake an evaluation of the American medical educational system, which was performed under the direction of Dr. Abraham Flexner, a young biologist at the Carnegie Institute. Dr. Flexner's report<sup>4</sup> was the most thorough analysis of the American medical educational system that had yet been undertaken, and he pointed out the main deficiencies of the system. Salaries of the medical educators had not kept pace with inflation, and had actually declined from 1900 to 1915. The expenditure for research by the institutions and states was grossly inadequate. In many schools faculty were undertrained, clinical facilities were inadequate, and research was not properly amalgamated with clinical teaching. Following the Flexner report, many of the weaker schools disappeared and the early 1920's marked the beginning of medical education in this country as a university discipline with definite academic standards. Schools were graded, graduates of doubtful schools were not licensed, and it became accepted that the faculty of the medical sciences should consist of experienced teachers who were able to engage in productive research and clinical practice, as well as student instruction. It was recognized that hospitals should be integral parts of medical schools and student tuition alone was

declared inadequate to maintain the activities of a medical school.

## Medical Education in Ohio

The development of medical education in Ohio and at The Ohio State University reflects in many ways the development of medical education in the country as a whole. Ohio has its own unique contribution to medical education and academic medicine, and an understanding of its history is essential to those trying to understand the current concept of academic medicine.<sup>5,6</sup> Following the Revolutionary War, two graduates of the Fairfield Medical School in New York State were among the citizens who settled in the village of Chagrin in the Connecticut Western Reserve in Northeastern Ohio. As the village grew, the citizens succeeded in obtaining a charter for a university. These two physicians were instrumental in steering the direction of this university to that of a medical school. The school was named Willoughby University of Lake Erie after the founder of the Fairfield School, Dr. Westel Willoughby. At this time, there were only two other medical schools in the state and there were no medical schools west of Ohio. The original medical school in Chagrin offered only a few lectures, some optional dissecting experience and clinical experience with preceptors, again in the form of an apprenticeship. The school, which opened in 1834, was conducted in the second floor of a brick building over a store and was attended by 25 students. By 1836 the school had moved into a new building, but in 1840 dissension arose within the faculty; in addition, the school outlived its welcome among the townspeople because of the questionable source of some of the dissecting material. As a result, the Legislature authorized Willoughby to move to Columbus in 1847. The period of 1847 through 1914 proved to be troubled times for medical education and academic medicine in Columbus, as there were several splits in the faculties resulting in the organization of several medical schools within the city. Finally, in 1914, The Ohio State University College of Medicine was established by the merger of the Starling-Ohio Medical College and The Ohio State University. Thus, The Ohio State University College of Medicine traces its history through six medical schools, beginning with the Willoughby Medical College of Columbus in 1847.

The size of The Ohio State University College of Medicine has grown rapidly, as evidenced by the fact that in 1934 there were only 85 members of the medical faculty, which by 1968 had increased to well over 1,000. The student body, which now numbers over 200 in a class, had a class size of 50 in the early 1920's. In 1944, an



expansion program was undertaken within the medical school, and the new hospital which we now use was completed in 1951. The policy of expansion has continued, resulting in a major medical complex.

### Goals to Be Met

It is thus clear that in the past several centuries academic medicine and medical education have become increasingly complex. New areas of responsibility have been added while few old ones have been deleted. These responsibilities are so intermeshed within the structure of medical education that the deletion of any one of them would make impossible the fulfillment of the role of delivering adequate medical care to the nation. It is an oversimplification to state that the only function of a medical school is to train the medical student. The responsibility of academic medicine is to train the physicians for tomorrow. A faculty not engaged in research will be teaching the practitioners of tomorrow the medicine of yesterday. In addition, teaching will be sterile and unimaginative; the new physician will be taught a science that is antiquated the day he graduates. The function of academic medicine is to guarantee adequate and constantly improving medical care, and this need cannot be met without the further achievement of scientific knowledge. This need is best met within the confines of an academic medical institution. Thus, both proper medical student education and the advancement of the clinical science of medicine demand that the faculty of a medical school engage in research.

It is evident that research and student education are closely linked; similarly, the clinical practice of medicine and student education are closely linked. The proper training of medical students must be conducted within an atmosphere of clinical excellence. In order for this to be achieved, the members of the medical faculty must be clinical practitioners. The medical school has a responsibility for setting high standards of clinical care, standards which will be transmitted to their students and later to the community. A faculty which is not actively engaged in the clinical practice of medicine will soon become unaware of the medical needs of the country and of the best methods of meeting those needs. It is impossible for a faculty that is divorced from day-to-day patient responsibilities to properly influence future physicians; it is equally impossible for them to be aware of the clinical problems that need to be solved if they are not engaged in the practice of medicine.

Thus, the proper education of students depends upon a practicing faculty that is engaged in research activities. There is, however, another area of responsibility for academic medicine. For many years the members of academic faculties

have preferred to remain aloof and isolated from the problems of community medicine and from the development of federal and state programs that are designed to change and improve health care delivery. We can no longer afford this isolationism. A system of health care delivery that permits the further training of students and specialists must be preserved. If we are to influence the direction in which these systems evolve, we must be willing to participate actively in national and local discussions concerning these programs. Organized academic medicine must allow its voice to be strongly heard through its scientific and political organizations. Thus, there are four pillars that will support and foster adequate medical care: student education, research, clinical practice, and community service.

### Conclusion

In my discussion of the historical development of academic medicine I mentioned some of the financial systems that tied together medical student education, research, and the clinical practice of medicine. In the earliest days of medical education, student fees paid directly to the teacher provided the sole source of income to the medical faculty. Because of the abuses of this system by the proprietary schools, and because this system limited the activities of the faculty, it was abandoned and several other systems were introduced. In the first half of this century the full-time system instituted at Johns Hopkins proved quite successful. Other institutions gained financial support for the medical faculties through a combination of patient fees and state, federal, and private funds. There is little doubt that all of these systems have their unique advantages, but also have their disadvantages. While competitive private practice is a superb system for the delivery of health care, it may be more appropriate for this competition in a medical school to be directed toward improving teaching, research, and the development of community programs. A recent survey<sup>7</sup> has suggested that the full-time system will not provide an adequate flow of patient material to support financially the departments or to provide the number of patients required for surgical education. Educational programs founded upon the concept of the indigent patient are antiquated and will not function in the latter 1970's. In view of the attitude of the current federal government, the disappearance of the indigent patient as a source of teaching material, and the inability of an institution to provide in full for adequate medical faculty salaries and research, it seems most likely that academic departments in the future will be organized around prepaid medical programs that will provide both patient material and



financial support for an institution to carry on its role.

### Summary

I have tried this morning to trace the evolution of academic medicine and I would like to leave you with a very specific message. To those of you considering entering academic medicine, I hope this brief presentation will provide a stimulus for obtaining further knowledge of medical history. Only through an understanding of the past development of medical education will you be able to solve its future problems. To those recent members of Alpha Omega Alpha who intend ultimately to enter community practice, you have the responsibility of forming a bridge between academic institutions and the practicing community. These two spheres of medicine must work more closely together and, as a recent medical school graduate and as a member of the practicing community, it will be your responsibility to narrow any differences between university and community medicine. It is obvious, therefore, that academic medicine

will continue to change and evolve. It will greatly depend upon the efforts of Alpha Omega Alpha members, within both university and community medicine, to provide adequate medical care by successfully directing the future evolution of academic medicine to assure that a proper balance exists between clinical practice, student education, research, and community service.

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## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

This 37-year-old man presents with a rapidly enlarging mass behind his right ear (Fig. 1). What are the diagnostic possibilities, and how should he be evaluated.

(See p. 276 of this issue for further information and discussion.)



FIG. 1. Patient presents with an asymptomatic, rapidly enlarging mass in posterior of his neck.

\*Dr. Miglets, Columbus, is Assistant Professor of Otolaryngology, The Ohio State University College of Medicine.  
Submitted February 22, 1973.

# Pelvic Exenterations in Gynecologic Cancer

JOHN G. BOUTSELIS, M.D.

IN SPITE OF FAVORABLE REPORTS during the past 20 years regarding the use of pelvic exenteration procedures in the management of recurrent cervical carcinoma, the medical profession, including many gynecologic surgeons, has continued to view such an operation with some degree of skepticism. The basis for this guarded attitude has been the high mortality rate noted in the early reports and the discouraging morbidity and complication rates that all surgical groups have found in their initial experiences with this operation. Additional causes for pessimism have been the degree of "mutilation," the rapidity with which recurrences may appear, and the relatively low five-year survival rates obtained.

During the past decade, the survival rates from pelvic exenteration have improved with the general acceptance of this operation as a primary procedure for advanced cervical cancer and earlier application of exenteration for recurrent carcinoma rather than the use of chemotherapy or reirradiation, which with rare exceptions, are palliative measures. In addition to a better selection of patients, other factors responsible for the improved salvage rates include improved surgical and anesthetic techniques, blood replacement modalities, and improved postoperative care.<sup>1</sup>

Pelvic exenteration was first performed successfully by Appleby<sup>2</sup> in 1943 for extensive carcinoma of the rectum, however, it was previously attempted twice in 1940 by Bricker and Modlin,<sup>3</sup> and the outcome was operative deaths. Brunschwig<sup>4</sup> intensified and popularized interests in this

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surgical procedure, developed it as a true cancer operation, and demonstrated the feasibility of removing the primary growth with its pelvic extensions to neighboring organs and regional lymph nodes with relative safety. Since Brunschwig's report in 1948, numerous reports have appeared in the literature relating their own experiences and that of others with this procedure.<sup>1,8,10-18</sup> Without exception, these authors concluded that the use of pelvic exenteration as a curative procedure deserves a place in the management of centrally recurrent carcinoma of the cervix following irradiation therapy and as the primary mode of treatment in other malignant tumors of the pelvis, including advanced, untreated cervical cancer.<sup>5</sup>

It is paramount importance in the successful outcome of pelvic exenterative procedure to shorten the usually prolonged operating time associated with this extensive operation. This can best be accomplished by using the "team-approach" method particularly in patients requiring both abdominal and vaginal-perineal surgery. Schmitz and others<sup>6</sup> have reported the many advantages of the team approach. When the operative time exceeds eight hours, it has been shown that there is a significant increase in morbidity and mortality rates compared with those patients who could be managed in a shorter period of time.<sup>6</sup> We certainly

From the Department of Obstetrics and Gynecology, The Ohio State University College of Medicine, Columbus, Ohio.

Submitted July 13, 1972.

concur with the team-approach method, and many of the patients reported in this series had the benefit of either a urologist or general surgeon working in close cooperation with the gynecologic surgeon.

### Clinical Material

Prior to 1960, only two ultra-radical operative procedures were performed for gynecologic cancer in the Department of Obstetrics and Gynecology at The Ohio State University Medical Center. During the past decade and in particular during the past five years, an additional 15 exenterations were performed. This shift toward curative exenterative surgery has been attributed to enthusiastic reports in the literature and the gratifying survival rates in treating patients with recurrent cervical carcinoma. In the present series, 13 patients had recurrent cervical carcinoma after complete radiation therapy, and four patients had extensive primary carcinoma of the vulva. This group of patients appears to constitute the ideal indication for primary or secondary operation by pelvic exenteration in gynecologic cancer patients, because death frequently follows with disease confined only to the pelvis in a majority of patients.<sup>9</sup> The initial diagnosis, therapy, indication for exenterative surgery, and the type of surgical procedure are noted in Table I. Although carcinoma involving the rectum spreads, characteristically by lymphatic metastases to the regional lymph nodes and may involve adjacent organs by local extension thus presenting an ideal indication for pelvic exenteration, the number of these patients in the present study was small. Pelvic exenterations for extensive radiation necrosis were not performed in our department because they are frequently associated with local sepsis, slough, hemorrhage, and fistulas, thereby making the patient more miserable during the terminal phase of life.

### Patient Selection

Pelvic exenteration has been employed as a secondary operation for radiation failures, although this procedure was used as a primary operation in four patients with advanced carcinoma of the vulva.

Although age has been considered in the overall assessment of operability, no patient was refused the operation on this account alone, providing the patient was judged to possess the physiologic and mental capabilities which would allow her to withstand the surgical procedure and make a satisfactory adjustment to the altered excretory and sexual functions. In this group of patients, the age ranged between 29 and 74 years with an average age of 46 years.

Complete medical evaluation was carried out on all patients with determination of electrolytes,

chest roentgenograms, urograms, electrocardiograms, lower gastrointestinal series, sigmoidoscopy, cystoscopy, etc. Blood volume studies were done whenever indicated in depleted patients. Distant metastases constituted a definite contraindication to the operation, and a detailed but reasonable search was made for their detection. All patients were properly screened to exclude the possibility of metastatic disease beyond the field of operation.

Although radiographic studies of the kidney and ureters and cystoscopic examination were carried out, they usually added little information concerning the operative resectability of the lesion.

The findings of bimanual examination of the pelvic organs are often difficult to interpret properly, and final opinions were rendered while the patient was under general anesthesia. Unless the degree of fixation was advanced, most patients were finally assessed under anesthesia. All borderline cases deserved and obtained exploration, since only operation and local dissection of the parametria can demonstrate unequivocally whether or not a lesion is resectable. Not infrequently after lateral dissection, lesions have been found to be less advanced than anticipated at the time of examination before or under anesthesia.

Pelvic exenteration has seldom been considered a satisfactory means of intentional palliation. Therefore, exploratory laparotomy was offered only to patients whose cancer was confined to the pelvis as determined by clinical, physical, isotopic, chemical, and roentgenographic studies. The presence of unilateral leg edema, sciatic leg pain, pyelographic evidence of bilateral ureteral obstruction, a fixed (frozen) pelvis in primary cases, and the unusual instance of a medically or psychiatrically unstable patient contraindicated exploratory laparotomy. Recent studies have shown that chest tomography, radioisotopic bone scans, and scalene node biopsy have prevented unwarranted laparotomies. The most frequent reason for intraoperative rejection is a frozen section diagnosis of tumor fixed to the common iliac vessels, invading the lateral pelvic wall, or metastatic spread beyond the confines of the pelvis.

During operative evaluation, all areas suspicious for tumor metastases and selected para-aortic lymph nodes were removed for frozen section analysis. (While waiting for the results of these tests, the lateral pelvic walls may be exposed by blunt finger dissection, allowing evaluation of lateral tumor extension to major vessels, sciatic nerve, or the pelvic wall itself.) Histologic documentation of invasion of the lateral pelvic wall or metastases to para-aortic nodes was ordinarily a contraindication to further surgery. As stated previously, patients with extrapelvic metastases were considered to be inoperable. However, peritoneal involvement within the pelvis, or perhaps the result of direct extension of malignancy to an adherent loop



of sigmoid or small bowel, does not contraindicate operation, and some survival may be obtained. In general, unless it is apparent that all malignant tissue can be excised, one should not proceed with the operation.

Results

The results of 17 pelvic exenterations are noted in Tables 1 and 2. In addition to the exenterative procedures, with radical Wertheim's operations and pelvic lymphadenectomy, four radical vulvectomies with femoral, inguinal, or pelvic

lymphadenectomy were performed in these 17 patients.

Of nine anterior exenterations, the ileal conduit (Bricker pouch) as a means of urinary diversion was performed in eight patients, and in one instance, the ureters were implanted into the sigmoid colon. Revision of the ileal conduit was necessary in one patient where torsion of the ileal pouch occurred with ureteral obstruction and anuria. In the one patient where the ureters were implanted into the sigmoid colon, subsequent acute fulminating pyelitis terminated fatally. As noted in Table 2, of nine patients with anterior exentera-

TABLE 1. Treatment and Results in 17 Pelvic Exenterations

| Age | Primary Diagnosis of Pelvic Cancer                  | Previous Therapy                     | Indication for Exenteration    | Type of Ultraradical Pelvic Surgery  | Status of Lymph Nodes | Survival Rate                  |
|-----|---|--------------------------------------|--------------------------------|--|-----------------------|--------------------------------|
| 70  | Cervix, stage II                                    | Radiation                            | Bladder extension              | Anterior exenteration; Bricker pouch   | +                     | Postoperative death (2 wk)     |
| 30  | Cervix, stage I                                     | Radiation; Wertheim                  | Rectovaginal extension         | Posterior exenteration   | —                     | Living without disease, 6 yr.  |
| 66  | Vulva; vaginal urethral extension                   | None                                 | Urethral and bladder extension | Radical vulvectomy + nodes; Wertheim-vaginectomy anterior exenteration; Bricker pouch      | +                     | Expired with disease, 6 mo.    |
| 46  | Cervix, stage II-B                                  | Radiation                            | Rectovaginal extension         | Posterior exenteration   | —                     | Living without disease, 5 yr.  |
| 29  | Cervix, stage II-B                                  | Radiation                            | Bladder and rectum extension   | Total exenteration; Bricker pouch  | —                     | Expired with disease, 6 yr.    |
| 36  | Cervix, stage II-B                                  | Radiation                            | Bladder extension              | Anterior exenteration; Bricker pouch   | +                     | Expired with disease, 8 mo.    |
| 38  | Cervix, stage III                                   | Radiation; infusion                  | Bladder extension              | Anterior exenteration; Bricker pouch   | —                     | Living without disease, 5 yr.  |
| 74  | Cervix, stage I                                     | Radiation                            | Bladder extension              | Anterior exenteration; Bricker pouch   | —                     | Living without disease, 3 yr.  |
| 62  | Cervix, stage II                                    | Radiation 1953<br>Vag. implants 1958 | Rectal extension               | Posterior exenteration   | +                     | Expired without disease, 9 yr. |
| 50  | Cervix, stage II                                    | Radiation                            | Bladder extension              | Anterior exenteration; ureterosigmoidostomy  | + Pyelitis            | Expired with pyelitis, 1 yr.   |
| 66  | Cervical stump, stage II                            | Radiation                            | Bladder extension              | Anterior exenteration; Bricker pouch   | —                     | Living without disease, 1 yr.  |
| 38  | Cervix, stage I                                     | Total hysterectomy; radiation        | Bladder extension              | Anterior exenteration; Bricker pouch   | —                     | Living without disease, 10 yr. |
| 71  | Vulva and rectum                                    | None                                 | Rectal extension               | Posterior exenteration, radical vulvectomy and nodes                                       | —                     | Living without disease, 3 yr.  |
| 56  | Cervix, stage II                                    | Radiation                            | Vaginal and bladder extension  | Anterior exenteration; Bricker pouch   | +                     | Expired with disease, 18 mo.   |
| 62  | Vulva and rectum                                    | None                                 | Rectal extension               | Posterior exenteration, radical vulvectomy, and pelvic lymphadenectomy; radiation to groin | +                     | Living with disease, 2 yr.     |
| 46  | Cervix, stage II                                    | Radiation                            | Bladder and rectal             | Total exenteration Bricker pouch   | +                     | Expired with disease, 10 mo.   |
| 47  | Vulva with extension to rectum, vagina, and urethra | None                                 | Urethra and rectal extension   | Total exenteration; radical vulvectomy, vaginectomy, and inguinal nodes Bricker pouch      | +                     | Living without disease, 15 mo. |

TABLE 2. Survival Rates in 17 Pelvic Exenterations

| Type of Exenteration   | No. of Patients | 5-Year Survivors | Expired With Disease Less Than 5 Years | Living Without Disease Less Than 5 Years |
|------------------------|-----------------|------------------|--|--|
| Anterior exenteration  | 9               | 2 (11.8%)        | 5                                      | 2  |
| Posterior exenteration | 5               | 3 (17.7%)        | 1                                      | 1  |
| Total exenteration     | 3               | 1 ( 5.9%)        | 1                                      | 1  |
| Totals                 | 17              | 6 (35.4%)        | 7 (41.1%)                              | 4 (23.5%)                                |

tion, five died with disease within five years of surgery, two are living without clinical disease less than five years, and two (11.8 percent) represent five-year survivors.

Five patients were subjected to a posterior exenteration, and only one of these patients died with disease within five years of surgery. Three patients (17.7 percent) represent five-year survivors, and one is living without disease less than five years.

Of three total exenterations, one patient died with disease and one is living without disease less than five years, while the third patient represents a five-year survivor.

In the entire group of 17 patients, the five-year survival rate was 35.4 percent with the best results obtained in those patients subjected to posterior exenterations.

### Complications

The clinically significant complications are listed in Table 3, and it should be emphasized that multiple complications were frequently noted in one patient.

There was one postoperative death with an acute myocardial infarction, bowel and urinary fistulas. A second patient died several months postoperatively after fulminating pyelonephritis from a ureteral sigmoidostomy.

It has been emphasized<sup>10</sup> that the majority of early postoperative complications are related to the development of bacterial infections either in the raw pelvis, abdominal incision, urinary tract, or ileal loop. The frequency of pelvic infection sequelae is not surprising considering the presence of a large open, frequently sloughing, and invariably infected pelvic cavity. This infected basin is "roofed" by adherent loops of intestine and omentum indicating that an element of pelvic peritonitis exists in most patients. Appropriate intensive antibiotic therapy and adequate drainage usually controls this postoperative complication.

Gastrointestinal complications, such as bowel obstruction and fistulas, are frequently associated with an improperly peritonealized raw pelvis. As noted in Table 3, four of 17 patients experienced these complications. Despite the variety of methods

for peritonealization, a completely satisfactory method useful in all cases has yet to be developed. Preservation of visceral and parietal peritoneum to cover the pelvis at the level of the sacropromontory has been utilized, but the amount of available peritoneum is usually insufficient. When sufficiently redundant, the contiguous sigmoid and cecum with their mesenteries can be used to cover the pelvic brim, as described by Schweitzer.<sup>11</sup> Unfortunately, while both methods keep small bowel and omentum up out of the pelvic cavity, perhaps preventing adhesions, obstruction, and fistula formation, they tend to create and perpetuate a large open pelvic cavity that becomes infected, sloughs, and produces problems that may require 6 to 12 months to subside completely. Similarly the use of a "pelvic lid"<sup>12</sup> of tantalum or mersilene mesh not only prevents bowel and omentum from dropping into and obliterating the large pelvic cavity but also provides additional problems in that such foreign materials are poorly tolerated in the infected pelvis. Many of these have to be removed at an early date. The experimental use of fetal membranes appeared encouraging but when used in humans, complete disintegration frequently occurs in seven to eight days following insertion.<sup>13</sup> The Mayo Clinic surgeons<sup>14</sup> have reported satisfactory results by mobilizing a large vascularized omental pedicle from the right side of the transverse colon, leading it down into the pelvis, and suturing it to the edge of the levator fascia. While allowing the abdominal viscera to descend and obliterate the large pelvic cavity, the omentum prevents potentially lethal adhesions, obstruction, and fistula formation in the small bowel. The sigmoid colon, when sufficiently redundant, may be used in most anterior exenterative procedures. In either case, we have found hemovac suction of the pelvis most helpful in draining the collection of fluid thereby expediting the healing processes and reducing postoperative morbidity.

Although pelvic packing for hemostasis is not necessary, it was used in two patients for hemostasis and to prevent intestinal prolapse. As a rule, such packing should be removed on approximately the fifth postoperative day.

Urinary tract problems appear to be one of the most distressing complications encountered in the present study. To minimize these complica-

tions, it is of paramount importance to select the proper modality of urinary diversion. Until recently, Barber and Brunschwig<sup>15</sup> continued to recommend ureterosigmoidostomy as the method of choice. Schmitz, et al<sup>12</sup> preferred the creation of a continent rectal reservoir in patients subjected to anterior exenterations. By diverting the fecal stream through a single-barrel sigmoid colostomy and closing the distal sigmoid, one should provide urinary continence and theoretically obviate many complications (fecal reflux, infection, stones, electrolyte disturbance, etc.) associated with ureterosigmoidostomies involving the intact bowel. There are many reports of favorable experience with the use of a rectal reservoir for urinary diversion after urologic operations. However, other authors<sup>14,16</sup> found this procedure unsatisfactory and advocate ileal or sigmoid conduits. These authors report experience with 26 sigmoid conduits and 26 ileal conduits and found this modality for urinary diversion very satisfactory for long-term preservation of the urinary tract. The ileal conduit appears to be the procedure of choice in anterior exenterations, and the sigmoid conduits in posterior and total exenterations. In the present study, all but one patient requiring urinary diversion was subjected to an ileal conduit. The most serious complication encountered in one instance was torsion of the ileal conduit with ureteral obstruction. Secondary revision of the conduit resulted in proper function of the urinary tract without further sequela.

The remaining postoperative complications are noted on Table 3 and are self-explanatory.

Comments

That exenterative operations can provide an appreciable cure rate of patients harboring recurrent pelvic cancer, especially carcinoma of the cervix, has been demonstrated by many institutions reporting significant experience with this procedure.<sup>1,9,10,12,18</sup> Galante reported a five-year survival rate of 34.5 percent with a 2.4 percent mortality rate, Symmonds 26 percent and 2.3 percent respectively, Deckers 48.5 percent and 10.2 percent respectively, Ketcham 38 percent and 7 percent respectively, and Brunschwig a five-year survival rate of 20 percent. In one of the largest series of 241 pelvic exenterations from Florence, Italy, Ingiulla reported a five-year survival rate of 21 percent for anterior exenterations, 35 percent for posterior exenterations, 6 percent for total exenterations, with an overall five-year survival rate of 21 percent. The five-year survival rate in the present study was 46.1 percent with a mortality rate of 6 percent. The gynecologists who continue to regard this operation with disfavor are those who have based their opinions on few operations.<sup>14,16</sup> They have unnecessarily abandoned this

TABLE 3. Immediate Postoperative Complications of Pelvic Exenterations

| Complications  | Number |
|--|--------|
| Postoperative death (14 days)  | 1      |
| Acute myocardial infarction  |        |
| Bowel and urinary fistulas   |        |
| Pelvic cellulitis + abscess  | 3      |
| Small or large bowel fistulas  | 3      |
| Small bowel obstruction  | 2      |
| Prolonged ileus  | 1      |
| (nasogastric tube 10+ days)  |        |
| Pelvic thrombophlebitis and arterial thrombosis necessitating arterial embolectomy | 1      |
| Septicemia   | 1      |
| Fatal pyelitis (ureterosigmoidostomy)  | 1      |
| Ileal loop complications:  |        |
| Urinary fistulas   | 2      |
| Pyelonephritis   | 1      |
| Hydronephrosis (transient)   | 2      |
| Hyperchloremia   | 1      |
| Torsion of ileal conduit with ureteral obstruction, hydronephrosis and anuria      | 1      |
| Total Complications  | 20     |

potentially curative operation and have returned to therapeutic measures of irradiation and chemotherapy, which are palliative in patients with recurrent malignancy.

Retrospective analysis in the present study and a review of recent literature<sup>1,9,10,12,18</sup> have convinced us that many of the operative and postoperative deaths can be avoided with the proper management of postoperative hypotension, oliguria, anuria, electrolyte disturbances, etc. As an example, constant monitoring of central venous pressure during and for several days after operation has provided considerable assistance in evaluating the patient's fluid and blood requirements. During recent years, with the abandonment of ureterosigmoidostomy as a means of urinary diversion, the complications have been reduced markedly, thereby decreasing both morbidity and mortality rates. Ureterosigmoidostomy was employed in one patient in the present study, and it eventually terminated fatally from acute pyelonephritis. All other patients were subjected to an ileal conduit procedure which was found to be most satisfactory. In this group of patients, the only postoperative mortality was a patient who experienced acute myocardial infarction two weeks postoperatively.

Although bowel complications are not listed as a cause of operative mortality in the present series, obstruction and fistulas unquestionably were factors in increased morbidity and prolonged hospitalization. Despite considerable efforts, postoperative bowel problems remained one of the two most troublesome complications directly related to our operative technic. Additional thoughts and research must be developed toward their prevention. It should be emphasized that patients who



have developed postoperative bowel and urinary complications are those who represent radiation failures. When an exenterative procedure is used as a primary operation, urinary and bowel complications are significantly reduced.<sup>10</sup> This was also our experience with four patients in the present series.

Rutledge<sup>17</sup> has emphasized that a more careful selection of patients for exenterative surgery will result in an increased survival rate, a steady decrease in operative morbidity, and will establish pelvic exenteration as a safe, worthwhile procedure. This philosophy was strictly adhered to in the present study, which may explain the relatively high five-year survival rate of 46.1 percent and a reduced mortality rate of 6 percent. Absolute contraindications to pelvic exenteration should include unilateral or bilateral leg edema, unilateral or bilateral ureteral obstruction, unilateral or bilateral leg pain typical of sciatic nerve root compression, a frozen pelvis in the untreated patient, and generally advanced age, senility, massive obesity, and significant medical disability.<sup>17</sup>

The presence of positive lymph nodes in patients with recurrent pelvic malignant tumor has a marked influence on the patient's survival. Although several authors have reported no survivors when lymph nodes were reported positive for tumor,<sup>1,5,14,16,18</sup> Deckers, et al<sup>10</sup> have reported 25 patients with positive nodes treated by exenteration as a primary procedure, and the survival rate was not adversely affected. In the present series, patients with positive nodes either died or are living with evidence of disease less than five years after surgery (Table 1). The explanation for this discrepancy is not apparent unless we differentiate between patients who are subjected to exenterative surgery for recurrent carcinoma and those who were previously untreated.

### Summary

Seventeen gynecologic pelvic exenterations have been performed at The Ohio State University Hospitals yielding a five-year survival rate of 46 percent. Of the 17 patients, 13 exenterations were for recurrent carcinoma of the cervix following complete radiation therapy and four were for extensive primary carcinoma of the vulva. A postoperative mortality rate of 6 percent represents one patient with acute myocardial infarction. Post-

operative morbidity has been discussed. The modality of choice for urinary diversion was the ileal conduit. Factors to reduce morbidity and mortality have been discussed. When indicated, pelvic exenteration can be a curative surgical operation.

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# Laparoscopy at Akron City Hospital

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LAPAROSCOPY HAS BEEN USED in the Department of Obstetrics and Gynecology at Akron City Hospital since August 1971. The purpose of this paper is to review our series of laparoscopy patients and to evaluate critically the usefulness and safety of laparoscopy at a community hospital. Laparoscopy is a method of direct visualization of the pelvic organs by endoscopic technic. In recent years this technic has gained new popularity, primarily because of the refinement of laparoscopic instruments. The development of a fiberoptic laparoscope has made it possible for the light source to be external to the patient, thus avoiding the possibility of thermal injury and electrical shock. The 180° lens on the laparoscope gives the operator a good panoramic view of the pelvis. Other developments in instrumentation now make it possible to do more than visualize the internal organs. It is now possible to perform tubal sterilization by coagulating and cutting the fallopian tubes, to biopsy the ovaries, to aspirate fluid from ovarian cysts or ascites, to lyse pelvic adhesions, and to coagulate implants of endometriosis.

The original term "peritoneoscopy" was used years ago to describe this technic. The history of peritoneoscopy goes back to 1901 when Kelling (in Germany) visualized the peritoneal cavity in dogs. The same technic was used on humans in 1910 in Germany, and in 1911 in America by Bernheim. The gastroenterologists have helped to keep the technic alive throughout the years. In 1937, Rud-dock in the United States reported the first large series including some tubal sterilizations.<sup>1</sup> The newer instruments are called laparoscopes and the number of hospitals and clinics now using them has mushroomed.

## Materials and Methods

Records were reviewed on all patients who underwent laparoscopy at our hospital from August

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1971 through March 1972. The total series of 71 patients had an average age of 28.4 years, with a range of 19 to 43 years. A history of previous abdominal surgery was taken into account in the selection of patients for laparoscopy. Sixteen of our patients had previous abdominal surgery as detailed in Table 1. Note that six of these were pelvic operations. Eight patients were obese, ranging from 12 to 79 pounds overweight, based on their height. Private patients comprised 54 (76 percent) of the series and clinic patients 17 (24 percent) of the series. Seven attending physicians and five resident physicians performed these procedures.

The indications for laparoscopy are shown in Table 2. Sterilization accounted for 39 patients, diagnostic laparoscopy in 31, including chronic pelvic pain, infertility, pelvic mass, and vaginal agenesis. One patient, who had previously undergone tuboplasty with placement of polyethylene tubal splints, had these polyethylene tubes removed by laparoscopy.

The technic used for laparoscopy was that described by Steptoe.<sup>2</sup> The Wisap CO<sub>2</sub> pressure regulator was used for controlled insufflation. The 5-mm Eder laparoscope used was made by the Eder Instrument Company; peritoneal insufflation of CO<sub>2</sub> was accomplished by using the Verres needle, which has a spring-loaded blunt trocar inside the needle. The Eder biopsy tong was used for grasping and coagulating the fallopian tubes. The Semm intrauterine cannula with negative suction was applied to the cervix so that the position of the uterus could be manipulated, and if

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hydrotubation was desired, methylene blue dye was injected through this into the uterus.

Anesthetic technic (Table 3) included 66 patients with general anesthesia using endotracheal intubation; three patients had general anesthesia without intubation and two had spinal anesthesia. The physical status of each patient was evaluated, relative to anesthetic risk: 85 percent were class 1, 13 percent were class 2, and 2 percent were class 3.

After the patient receives her anesthetic, the Semm intrauterine cannula is applied transvaginally, and a Foley catheter is placed in the bladder. The abdomen is prepared and draped as for a pelvic laparotomy. The patient is placed in 15 to 30 degree Trendelenburg position. A 1-cm transverse incision is made through the skin in the inferior ridge of the umbilicus, the Verres needle is inserted into the peritoneal cavity, and 3 to 4 liters of CO<sub>2</sub> is insufflated to achieve abdominal distention. A 6-mm trocar with surrounding sheath is then placed through the same incision, the trocar withdrawn, and the 5-mm laparoscope is inserted through the sleeve. The pelvic organs can then be visualized. However, for better visualization and manipulation, a second trocar is inserted in the right or left lower quadrant and a probe or operating instrument is inserted through this second sleeve. When the procedure is completed, the instruments are withdrawn and a single skin clip or suture is placed in each small incision. The intrauterine cannula is removed, and the patient is awakened and taken to the recovery room.

The technic of tubal sterilization is summarized in Table 4. In one patient, each tube was coagulated once. In 11 patients, each tube was coagulated once and a segment was excised; in 12 patients, each tube was coagulated twice but no segment was excised; and in 12 patients, each tube was coagulated twice and a segment was excised.

Results

*Sterilization.*—The results of the 39 laparoscopies done for sterilization are summarized in Table 5. In 36 patients (92 percent) the procedure was successful. Laparotomy was necessary in three patients. Two of these had pelvic adhesions, making the tubes inaccessible, one of which had a past history of cholecystectomy and appendectomy. The third patient was obese (45 lb overweight) and entrance into the abdominal cavity by the laparoscope could not be accomplished.

*Diagnostic Laparoscopies.*—The results of the 17 diagnostic laparoscopies done for chronic pelvic pain are reviewed in Table 6. A normal pelvis was found in 41 percent (7 out of 17 patients), pelvic adhesions were found in 29 percent (five patients), pelvic inflammatory disease was found in 24 percent (four patients), and one

TABLE 1. Laparoscopy Patients with Previous Abdominal Surgery

|                                  |    |
|----------------------------------|----|
| Appendectomy                     | 8  |
| Cholecystectomy and appendectomy | 2  |
| Hysterectomy                     | 2  |
| Adnexal surgery                  | 4  |
| Total                            | 16 |

TABLE 2. Indication for Laparoscopy

| Indication                    | No. of Patients |
|-------------------------------|-----------------|
| Sterilization                 | 39              |
| Diagnosis                     | 31              |
| Chronic pelvic pain           | 17              |
| Infertility                   | 10              |
| Pelvic mass                   | 3               |
| Vaginal agenesis              | 1               |
| Removal of polyethylene tubes | 1               |
| Total                         | 71              |

TABLE 3. Type of Anesthetic Technic Used in 71 Laparoscopies

| Technic  | No. of Patients |
|--|-----------------|
| General anesthesia with endotracheal intubation    | 66              |
| General anesthesia without endotracheal intubation | 3               |
| Spinal anesthesia                                  | 2               |

TABLE 4. Technic of Laparoscopic Sterilization

| Technic  | No. of Patients |
|--|-----------------|
| Each tube coagulated once                        | 1               |
| Each tube coagulated once and a segment excised  | 11              |
| Each tube coagulated twice                       | 12              |
| Each tube coagulated twice and a segment excised | 12              |
| Total  | 36              |

TABLE 5. Results of Laparoscopic Sterilizations

| Outcome                                      | No. of Patients |
|--|-----------------|
| Successful laparoscopic tubal sterilizations | 36 (92%)        |
| Laparotomy indicated                         | 3               |
| Adhesions precluding laparoscopic tubal      | 2               |
| Obesity precluding successful laparoscopy    | 1               |
| Total  | 39              |

patient was diagnosed as having a pelvic congestion syndrome.

Table 7 summarizes the findings of the ten patients evaluated for previously unexplained infertility. Polycystic or sclerocystic ovaries were found in three patients, one of whom also had adhesions and a dermoid cyst. Tubal occlusion was found in three patients, endometriosis in two patients, and a normal pelvis in two patients.

Three patients underwent laparoscopy for pelvic masses. Two of these were found to have sub-



acute tubo-ovarian abscesses and one patient had a tubal pregnancy.

The patient with congenital absence of the vagina was found by laparoscopy to have no uterus and only streak ovaries. Artificial construction of the vagina followed the laparoscopic examination. A follow-up karyotype revealed her to be a mosaic Turner's syndrome with XX/XO mosaicism. On the basis of the findings during diagnostic laparoscopies, seven patients were submitted to laparotomy for definitive surgery (Table 8), and future definitive surgery if indicated, could be discussed intelligently with other patients.

**Complications.**—The incidence of complications associated with laparoscopy are shown in Table 9. The most serious reported complications are gastrointestinal perforation and bleeding from injury to a major intra-abdominal vessel.<sup>1,3</sup> We had none of these in our series. The bleeding from the tubes when divided with the electrical current or accidentally torn during sterilization was easily controlled by additional coagulation under direct laparoscopic vision.<sup>4</sup> The hematomas of the ovary and broad ligament were small and self-limited and required no operative intervention. The uterine perforation by the Semm intrauterine cannula had no sequelae, the patient did well, never requiring any pain medication, and she was discharged on the first postoperative day.

Pneumoperitoneum could not be obtained in one patient who was 45 lbs overweight, and sev-

TABLE 9. Incidence of Complications Associated with Laparoscopy in 71 Patients

| Complication                                   | No. of Patients |
|--|-----------------|
| <b>Major Complications</b>                     |                 |
| Mortality                                      | 0               |
| Bowel perforation                              | 0               |
| Gastric perforation                            | 0               |
| Bleeding from major vessel                     | 0               |
| <b>Minor Bleeding Problems</b>                 |                 |
| Fallopian tube                                 | 2               |
| Parietal peritoneum                            | 1               |
| Hematoma of ovary                              | 1               |
| Hematoma of broad ligament                     | 1               |
| <b>Minor Complications</b>                     |                 |
| Uterine perforation by intrauterine cannula    | 1               |
| Temporary Bovie unit failure                   | 3               |
| Failed pneumoperitoneum                        | 1               |
| Difficulty obtaining pneumoperitoneum          | 6               |
| Wound infection                                | 0               |
| <b>Late Complication Following Laparoscopy</b> |                 |
| Pelvic abscess with peritonitis                | 1               |

TABLE 10. Postoperative Stay of 60 Patients Undergoing Laparoscopy

| No. of Days         | No. of Patients |
|---------------------|-----------------|
| 1                   | 31              |
| 2                   | 21              |
| 3 or more           | 7               |
| Diagnostic tests    | 3               |
| Continued pain      | 2               |
| Exacerbation of PID | 1               |
| No apparent reason  | 1               |
| Outpatient          | 1               |

eral attempts were required in six other patients before successful insufflation of CO<sub>2</sub> was accomplished. When this difficulty is encountered, it is usually easy to detect, because the CO<sub>2</sub> pressure gauge indicates an abnormally high pressure as subcutaneous emphysema develops, and the tip of the Verres needle does not feel free in the peritoneal cavity. In each of these six patients, however, laparoscopy was successfully completed.

We had no wound infections that we know of, however, one of the tubal sterilization patients was readmitted on the third postoperative day with abdominal pain and fever and then developed generalized peritonitis which localized to a pelvic abscess. She gradually improved with intensive antibiotic therapy and was discharged in two weeks.

**Length of Hospital Stay.**—The length of stay in the hospital after laparoscopy is summarized in Table 10. Excluded are the patients that also underwent laparotomy. Thirty-one patients were discharged the first postoperative day, 21 on the second day, and seven patients stayed three or more days. Several of these stayed for diagnostic tests. The one patient who had laparoscopy done as an outpatient was discharged three hours postoperatively.

**Morbidity.**—Postoperative pain seems to be fairly mild after laparoscopy, even when tubal co-

TABLE 6. Results of Diagnostic Laparoscopy for Chronic Pelvic Pain

| Findings                    | Patients |     |
|-----------------------------|----------|-----|
|                             | No.      | %   |
| Normal pelvis               | 7        | 41  |
| Pelvic adhesions            | 5        | 29  |
| Pelvic inflammatory disease | 4        | 24  |
| Pelvic congestion syndrome  | 1        | 6   |
| Totals                      | 17       | 100 |

TABLE 7. Results of Laparoscopy in 10 Patients with Previously Unexplained Infertility

| Findings  | No. of Patients |
|---|-----------------|
| Polycystic ovaries                                | 2               |
| Polycystic ovaries, adhesions, and a dermoid cyst | 1               |
| Tubal occlusion                                   | 3               |
| Endometriosis                                     | 2               |
| Normal pelvis                                     | 2               |

TABLE 8. Indications for Laparotomy in 7 Patients After Diagnostic Laparoscopy

| Indication                   | No. of Patients |
|------------------------------|-----------------|
| Infertility surgery          | 4               |
| Pain due to pelvic adhesions | 1               |
| Pain due to old PID          | 1               |
| Ectopic tubal pregnancy      | 1               |

agulation is done (Table 11). Excluding those patients with preoperative pain, 55 patients were evaluated for pain, and 23 (42 percent) of this number never complained of any pain or took any analgesic medication. Twenty-one (38 percent) complained of abdominal or incisional pain, six (11 percent) had shoulder pain, and five (9 percent) had pain at other sites. An oral analgesic was used by 14 patients and 14 patients used an intramuscular narcotic. One third of the patients had nausea or vomiting postoperatively. Only three patients had a temperature over 38 C (100.4 F) postoperatively and antibiotics were rarely used in this series.

**Anesthesia.**—One of the major criticisms of laparoscopy has been the recommended anesthetic technic.<sup>1,5,6</sup> As detailed previously, 66 of our 71 patients had general anesthesia with endotracheal intubation and assisted ventilation. This has been recommended along with the use of muscle relaxants so that there is less likelihood of the bowel moving into the operative field of the pelvis, and gastric distention does not occur to give rise to possible gastric perforation with the needle or trocar. Table 12 summarizes anesthesia time for our laparoscopies. The largest number of patients were in the 31- to 90-minute range, the average time being 67 minutes. The first half of our cases averaged 78 minutes, the last half—63 minutes. The range of time was 20 to 180 minutes, the 180-minute procedure being the first one in this series. One would expect a further decrease in average time as each surgeon and the operating room personnel become more familiar with the procedure and equipment.

There were no major complications of anesthesia noted in these 71 patients. However, the

author recalls several patients in which a transient cardiac arrhythmia was seen on the monitor. In each case, the arrhythmia either disappeared spontaneously or responded to increased oxygenation and ventilation.

Blood loss for a laparoscopic procedure is usually minimal. The average blood loss for our laparoscopies was 13 cc with the range from 1 cc to 50 cc. In many cases, the operator recorded "none" for blood loss, in which case a figure of 5 cc was used in calculating the average.

Discussion

Laparoscopy has been used in this hospital for less than a year. Our results over all have been good. The mortality was zero and the morbidity minimal. The one severe complication of postoperative peritonitis and pelvic abscess could have been related to laparoscopy. Unrecognized bleeding resulting in an infected hematoma, infection introduced by the laparoscope, or an unrecognized perforation of the bowel could have occurred to explain the postoperative illness. Since a laparotomy was not deemed necessary on this patient, we do not know the precise etiology of her illness.

As a group, the patients that were sterilized by laparoscopy were well satisfied with the procedure because of the short hospital stay, the minimal discomfort postoperatively, the small incisions, and the early return of normal activity that it allows. The literature on laparoscopy assures us that this type of tubal sterilization is just as effective as the conventional partial salpingectomy, as long as adequate coagulation is done on each tube.<sup>5,7</sup> Although our series is not large enough or long enough for evaluation of failure rate, other series generally report a 0.3 percent failure rate. Sterilization by this method does reduce the patient days needed for our scarce hospital beds, and with the minimal morbidity, this can now be recommended as an outpatient procedure.<sup>8</sup> Only one of our series was done as an outpatient, polyethylene tubes being removed by laparoscope after previous tuboplasty. Laparoscopic sterilization can also be done in the immediate postpartum period although we have not done any of these in this early series.

Previous abdominal surgery does not appear to be a contraindication to laparoscopy, as 15 out of 16 patients with such a history had successful laparoscopy. Laparoscopy in our hospital has been done with a major anesthetic. However, in some hospitals,<sup>5,8</sup> it is being done with a local anesthetic and neuroleptanalgesia, using Innovar.<sup>R</sup> This has been recommended by some for the procedure as an outpatient. However, a well-administered general anesthetic even with intubation leaves the patient much more alert in two hours than a local anesthetic supplemented heavily with a tran-

TABLE 11. Postoperative Pain in Laparoscopy Patients

| Type of Pain            | No. of Patients | %   |
|-------------------------|-----------------|-----|
| Location of pain        |                 |     |
| Abdominal or incisional | 21              | 38  |
| Shoulder                | 6               | 11  |
| Other sites             | 5               | 9   |
| No complaint of pain    | 23              | 42  |
| Total*                  | 55              | 100 |

\*Total of 55 patients after exclusion of those with laparotomies and significant preoperative pain.

TABLE 12. Anesthesia Time for Laparoscopy

| Time           | No. of Patients |
|----------------|-----------------|
| 0-31 min       | 4               |
| 31-60 min      | 27              |
| 61-90 min      | 25              |
| > 90 min       | 8               |
| Mean time      | 65 min          |
| Avg time       | 67 min          |
| First 36 cases | 78 min          |
| Next 35 cases  | 63 min          |
| Range of time  | 20 to 180 min   |



quilizer and narcotic with their drug hangover. In addition, there is less risk of the major complications of laparoscopy if the patient is deeply anesthetized.<sup>1</sup> The anesthetic time is prolonged in a few of these cases. It must be kept in mind, however, that this is the total anesthesia time, which includes intubation, insertion of uterine cannula, preparation of the abdomen, laparoscopy, and extubation of the patient. In addition, in a teaching hospital such as ours, a considerable amount of time was spent in teaching the procedure to attending and resident physicians with several observers looking through the laparoscope in many of these cases.

The value of laparoscopy is obvious in unexplained infertility, chronic pelvic pain, and obscure pelvic pathology. In 80 percent of the unexplained infertility cases, pelvic disease was found. This provides an intelligent basis for further medical or surgical treatment and avoids unnecessary laparotomy, which may only produce damaging adhesions. Chronic pelvic pain is a frequent gynecologic complaint and it often escapes a certain diagnosis. An etiology for chronic pelvic pain was found in 60 percent of our patients, and the other 40 percent could be confidently reassured of the absence of pelvic disease. Laparotomy was avoided for patients in whom no disease was found, thus avoiding a long postoperative recovery and extended hospital stay. The diagnosis of ectopic pregnancy was made in only one case in this series, but it was ruled out by laparoscopic examination in several patients with pelvic pain.

### Summary

A series of 71 patients underwent laparoscopy at Akron City Hospital. Thirty-nine of these were done for sterilization, and 31 were done for diagnosis. Most of the patients received endotracheal anesthesia. Of the 17 patients with chronic pelvic

pain, ten were found to have pelvic disease, and seven had a normal pelvis. An etiology for unexplained infertility was found in eight of ten patients. In the three patients with pelvic masses, two had subacute tubo-ovarian abscesses, and one had an ectopic pregnancy. Laparotomy was avoided when no disease was found, thus avoiding a long postoperative recovery and extended hospital stay. No major complications such as bowel or gastric perforation occurred in this series, although one patient developed a pelvic abscess. Five minor bleeding problems occurred which did not require laparotomy. The majority of patients were discharged on the first postoperative day, and only seven of them stayed three days or more. Forty-two percent required no postoperative analgesic, and pain was minimal in the rest. Over-all patient acceptance of this procedure was excellent. In our experience, laparoscopy has proved to be a safe and useful technic for female sterilization and for the diagnosis of obscure pelvic disease.

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## Discussion of E.N.T. Case of the Month

(continued from p. 265)

A rapidly enlarging cervical mass in an adult is most likely a lymph node metastasis from a primary cancer in the head and neck. Since the lymphatic drainage from the nasopharynx is directed toward the posterior triangle of the neck (where this lesion is located), examination of this area is essential in his evaluation. In this instance, an ulcerative lesion was found in the nasopharynx which upon biopsy proved to be a squamous carcinoma.

If physical examination fails to reveal an obvious primary site then, blind biopsy of the

nasopharynx, tonsil, and base of tongue should be done. Submucosal cancers in these areas which are not evident during the initial physical examination may be detected by this method.

When nasopharyngeal carcinoma is present, radiographic evaluation of the base of the skull should be done to determine if the tumor has extended into this area. The close approximation of nasopharyngeal cancers to essential structures such as the internal carotid artery and base of the skull, make wide surgical excision impossible. Carcinomas in this area are usually treated with radiation therapy.



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are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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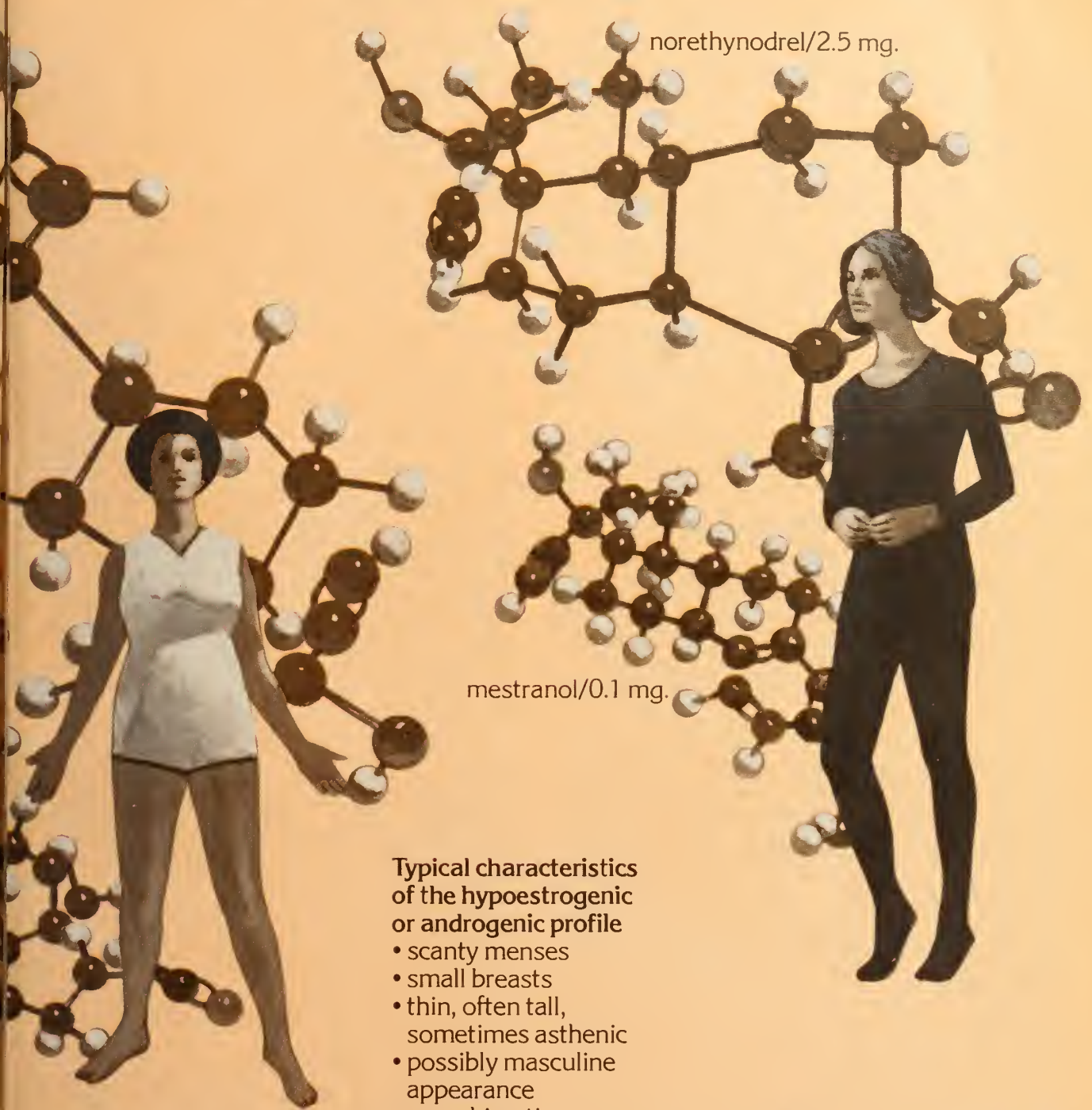
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**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1-3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible

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influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factor VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> uptake values; metyrapone test and pregnanediol determination.

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The Special Note, Contraindications, Warnings, Precautions and Adverse Reactions listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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# A Clinical Study of Pulmonary Embolic Disease

V. KRISHNASWAMI, M.D.; P. C. BARMAN, M.D.; PAUL L. BELL, M.D.; AND CHARLES D. COBAU, M.D.

**C**LINICAL FEATURES of pulmonary embolic disease are so varied that there is no single certain way of pinpointing the diagnosis. High index of suspicion leads one to undertake all available modern diagnostic methods. It has been shown that in only 50 percent of patients who showed evidence of pulmonary embolism at autopsy, a correct antemortem diagnosis was made.<sup>1,2</sup> The diagnosis of pulmonary embolism depends on keen clinical awareness aided by recent diagnostic approaches like lung scan and pulmonary arteriography. In order to assess the diagnostic accuracy of various laboratory studies and to review the various clinical facets of the disease, we analyzed all the hospital records of patients who were discharged from, or who died at, the Toledo Hospital, Toledo, Ohio with the diagnosis of pulmonary embolism or infarction in the period between June 1, 1969 and May 31, 1970. We also studied the incidence of certain clinical states considered favorable for the development of pulmonary embolism.

## Materials and Methods

Under the term pulmonary embolic disease we include pulmonary embolism and infarction. There were 164 charts of patients with the diagnosis of pulmonary embolism or infarction between June 1969 and May 1970. We discarded 48 of these charts since they did not contain sufficient information. The remaining 116 charts were analyzed for the following factors: age and sex; presence of favorable predisposing conditions such as postoperative period, postpartum period, and

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oral contraceptive intake; clinical evidence of thrombophlebitis; symptomatology and mode of presentation; diagnostic studies including chest roentgenogram, electrocardiogram, lung scan, and pulmonary arteriography; mortality; findings at autopsy; and associated uncommon conditions.

## Results

Of the 116 patients studied, 51 were men (44 percent) and 65 women (56 percent). Table 1 shows the incidence of pulmonary embolic disease in various age groups in both men and women. Slight preponderance of women over men is evident. This becomes more conspicuous below the age of 40 years where it is seen that 26 percent of the total number of women with pulmonary embolism fell in this group, whereas only 12 percent of the total number of men were less than 40 years old. On analyzing the incidence of several known favorable preceding conditions, it is noted that 25 patients were in the immediate post-

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Submitted June 1, 1972.



operative period, viz, within ten days after major surgery. To put it differently, more than 20 percent of patients who developed pulmonary embolism did so within ten days after surgery. There were five women (4.3 percent) in the postpartum period. Of the total number of women, 9.3 percent gave a history of oral contraceptive intake for a period ranging from a few weeks to several months. Definite evidence of thrombophlebitis of the legs by history or clinical observation was available only in 13 patients (11 percent). Electrocardiographic evidence of recent myocardial infarction was seen in 12 patients (10 percent), and congestive heart failure of various etiology was present in 17 patients (14.1 percent).

In Table 2, the incidence of various clinical states which are considered conducive to the development of pulmonary embolic disease are compared. The variety of symptoms with which the patients presented at the time of admission is shown in Table 3. It is seen that 58 percent had pleuritic chest pain, 55 percent had shortness of breath, 13 percent hemoptysis, and 3.4 percent were admitted in a state of circulatory collapse.

Table 4 shows various diagnostic procedures undertaken and the percentage of their accuracy in helping to make the diagnosis. X-ray studies of the chest in various views were done on all the patients. Sixty-eight patients (58.6 percent) showed evidence of infiltration in the lung compatible with a diagnosis of pulmonary infarct. Of the 113 patients in whom the conventional 12-lead electrocardiograms were done, only 14 (12.4 percent) showed changes such as deep S wave in lead I with Q in lead III, right heart strain pattern, right bundle branch block pattern, and change in the axis. A perfusion lung scan was performed in 82 (72 percent) patients, 65 percent of whom showed a perfusion defect corresponding to the site of pulmonary infiltration in the chest film. More defects in the lung scan than suggested by the chest x-ray study were seen in 15 patients. In only ten patients was the lung scan normal, and it did not contribute to the diagnosis. Serum enzyme studies, which were done in 99 patients, showed elevated lactic acid dehydrogenase (LDH) in 58 patients, high serum glutamic oxaloacetic transaminase (SGOT) in 13 patients, and high creatine phosphokinase (CPK) in six patients. Some patients showed elevation of more than one enzyme. Hydroxybutrate dehydrogenase (HBD) fraction of LDH was not done in these patients.

Of the 116 patients who were diagnosed to have pulmonary embolic disease, 18 died while in the hospital, giving an overall mortality rate of 15.5 percent. Patients who died were analyzed as to the age group and the time interval between diagnosis and death, and the result is shown in Table 5. The higher mortality in the older age group

is noted and is probably attributable to a long standing, serious underlying disease. It is also seen that 55 percent of the mortality was within 24 hours of the diagnosis. Autopsy studies were available in 13 of the 18 patients who died. In 11 patients, the clinical, antemortem diagnosis of pulmonary embolic disease as the cause of death was confirmed. One patient had massive pneumonia, and the other showed intra-alveolar hemorrhage suggestive of Goodpasture's disease. It was interesting to note that in seven patients (6 percent) a pulmonary embolic episode was associated with or secondary to multiple injuries sustained in automobile accidents.

Discussion

The analysis of the 116 patients with pulmonary embolic disease has revealed some interesting though not altogether unexpected aspects of the disease. Taking age and sex into consideration, there appears to be a slight preponderance of females in the ratio of 1.25:1. When we consider the younger age group between 19 and 40 years, the incidence among women (26 percent) was

TABLE 1. Age (Years) Group Distribution in Men & Women

|       | 19 & Below<br>% | 20 to 30<br>% | 40 to 50<br>% | 60 to 79<br>% | 80 & Above<br>% |
|-------|-----------------|---------------|---------------|---------------|-----------------|
| Men   | nil             | 5.8           | 16.6          | 20.0          | 11.7            |
| Women | 1.5             | 12.3          | 14.5          | 16.9          | 10.7            |

TABLE 2. Percentage of Patients in Various Clinical State Favorable to Pulmonary Embolism

|                              |      |
|------------------------------|------|
| Postoperative period         | 21.5 |
| Postpartum period            | 4.3  |
| Oral contraceptives          | 9.3  |
| Clinical thrombophlebitis    | 11.0 |
| Recent myocardial infarction | 10.2 |
| Congestive heart failure     | 14.1 |

TABLE 3. Mode of Presentation

|                      | %    |
|----------------------|------|
| Chest pain           | 58.0 |
| Hemoptysis           | 13.0 |
| Shortness of breath  | 55.0 |
| Circulatory collapse | 3.4  |

TABLE 4. Contribution of Various Diagnostic Procedures for a Positive Diagnosis

|                         | %    |
|-------------------------|------|
| Chest x-ray             | 58.6 |
| Electrocardiogram       | 12.5 |
| Lung scan               | 65.0 |
| Serum enzymes elevation |      |
| SGOT                    | 13.0 |
| CPK                     | 6.0  |
| LDH                     | 58.0 |



more than twice that of men in the same age range (12 percent). The cause of this must necessarily lie in factors to which women of this age group are exposed. The two factors are pregnancy and oral contraceptive intake, both of which are known to favor venous thromboembolism. Unfortunately, in this study there was no consistent record of negative history, but those who had positive history were recorded. It is seen that 9.2 percent of women with pulmonary embolic disease have been on oral contraceptives for a varying period at the time of the episode. Tietze<sup>3</sup> reported the incidence of venous thromboembolism among women on birth control pills between the ages of 15 and 49 years, as 4.6 per 1000 against an incidence of 1.6 per 1000 for other nonpregnant women of the same age group, who are not on birth control pills. Vessey and Doll<sup>4</sup> estimated that about 1 in every 2000 women using birth control pills are admitted to the hospitals with idiopathic venous thrombosis every year. It is interesting to note that clinical evidence of thrombophlebitis was obtained in only 11 percent of the patients. This does not rule out silent deep-vein thrombosis. Among other favorable predisposing conditions, it is found that 10 percent of patients had recent myocardial infarction and 14.6 percent of patients were in congestive heart failure of various etiology.

Considering the symptomatology of this disease, it is seen that 58 percent of patients complained of pleuritic-type chest pain, 13 percent of patients had hemoptysis, 55 percent had shortness of breath, and 3.4 percent were in acute circulatory collapse. It is worth emphasizing that there were 42 percent of patients who never had any chest pain, 87 percent did not have any hemoptysis, and 45 percent of patients had no shortness of breath. The triad of chest pain, hemoptysis, and shortness of breath is infrequent enough to be stressed. This triad was seen only in 13 percent of patients as reported by Hildner and Ormand.<sup>5</sup> Schwaber<sup>6</sup> gives the following data regarding the frequency of symptoms in acute pulmonary embolic disease: dyspnea and pleuritic pain 50 to 100 percent, cough 50 to 75 percent, hemoptysis, syncope, apprehension, fatigue, substernal oppression, and abdominal pain all under 25 percent.

Among the diagnostic methods available, lung scan and pulmonary arteriography are the least fallible. Perfusion lung scan, however, may yield many false positive results. It is well known that the findings of chest x-ray, if positive, are at best only suggestive. They do not show the difference between inflammation and infarction. In this series, 58.6 percent of the chest x-ray films were suggestive of pulmonary infarction or embolism. It is observed that the electrocardiogram appears to be the least sensitive of all the diagnostic aids. Only 12.5 percent of patients' electrocardiograms showed changes such as right atrial hypertrophy,

TABLE 5. Correlating Mortality and Age Group with Time Interval Between Diagnosis and Death

| No. of Patients That Died | Years of Age                |
|---------------------------|-----------------------------|
| 2                         | Below 50                    |
| 3                         | 51 to 60                    |
| 4                         | 61 to 70                    |
| 9                         | 71 and above                |
| Time Interval             |                             |
| 5                         | Between Diagnosis and Death |
| 5                         | Within 12 hrs.              |
| 6                         | Between 12 and 24 hrs.      |
|                           | After 24 hrs.               |

In 2 patients diagnosis was made post mortem.

right heart strain pattern, S<sub>1</sub> Q<sub>3</sub> pattern, and axis deviation. Hildner and Ormand<sup>5</sup> found normal electrocardiograms in 72 percent of patients with pulmonary embolism. Elevation of serum LDH in the presence of normal CPK and SGOT will usually suggest pulmonary embolic disease. Lung tissue is relatively devoid of CPK. Hydroxybutyrate dehydrogenase (HBD) is the fraction of LDH that is specifically elevated in myocardial damage. Hence, elevated LDH in the face of normal HBD, SGOT, and CPK will very strongly suggest pulmonary embolic disease and help to rule out myocardial infarction, which is the only other condition that can clinically simulate this.<sup>7</sup> In this series, 58 percent of patients showed an elevated LDH, 13 had elevated SGOT, and six had increased level of CPK. Patients who had elevated SGOT and CPK probably had myocardial damage as well.

Perfusion lung scan is a more useful procedure and, if available, should be done in every case of suspected pulmonary embolic disease. In this study, 65 percent showed a positive scan. Hildner and Ormand<sup>5</sup> reported 60 percent positive results for lung scan. Poulouse, et al<sup>8</sup> cited 33 percent positive lung scans in a study of 74 patients. Twelve of their patients who had a negative lung scan also had negative pulmonary arteriography. However, it is well known that perfusion defects can occur in inflammatory as well as atelectatic lesions. DeNardo, et al<sup>9</sup> suggested that the combined use of ventilatory lung scan using xenon 133 and perfusion lung scan, increases diagnostic accuracy, especially in patients with pulmonary embolism without infarction. They studied 15 patients by this method, ten of whom had arteriographically documented pulmonary embolism. These patients showed underperfused but normally ventilated areas. Five other patients with pulmonary diseases other than embolism or infarction showed ventilatory abnormalities equal to or exceeding that of perfusion defects. Pulmonary arteriography, which is a vitally important diagnostic procedure, was done only in four patients in this series, two of whom showed positive angiographic evidence of pulmonary embolism. With this small number, one cannot draw a fruitful conclusion. Poulouse, et al,<sup>8</sup>

in a study of 74 patients with pulmonary embolism, made a comparison of pulmonary angiography and lung scan and found that 33 percent showed segmental perfusion defect. Out of these, 75 percent of patients showed positive angiography. Of the 38 percent of the total patients who showed diffuse patchy nonsegmental defects in lung scan, only 25 percent were positive by angiography. This suggests that lung scan and angiography are corollary to one another and must be done within the first 24 hours in all patients suspected of pulmonary embolism.

Recently Szucs, et al<sup>10</sup> reported a prospective study of 50 patients with angiographically proven diagnosis of pulmonary embolism and found that only nine patients showed electrocardiographic changes and also found that nonspecific chest x-ray findings were present (infiltration, effusion, elevated diaphragm, etc) in 71 percent. LDH was increased in 83 percent but SGOT and bilirubin had little value. Abnormal lung scan was found in 48 percent, in which there were no false negatives but many false positives. They found that arterial hypoxemia and hypocarbia coupled with lung scan were the most useful diagnostic aids. A mortality rate of 15.5 percent in this series is about the same as other reports. It is interesting to note that seven patients had pulmonary embolism associated with multiple injuries sustained in automobile accidents. It is also an interesting fact that more than 55 percent of those who died did so within 24 hours after the episode, making it imperative that one must make early diagnosis of this condition so that a fruitful and rational therapeutic approach can be undertaken.

### Summary

One hundred and sixteen patients with the diagnosis of pulmonary embolism or infarction were studied by retrospective analysis of the case records. It is noted that there was more than double the number of patients among women below 40 years of age as compared to men of the same age group. Among the postulated causes, oral contraceptive intake may be an important one. More than 20 percent of the patients developed

pulmonary embolism within ten days after surgery. The low rate of diagnostic accuracy of chest x-ray, electrocardiography, and serum enzymes is brought out. Lung scan and pulmonary arteriography seem to be the two important procedures which are mandatory for the early diagnosis. The overall mortality rate was 15.5 percent and it is noted to be higher in the elderly patients. The often-sought-for, preceding clinical thrombophlebitis was seen only in 11 percent of the patients. It is interesting to note that seven patients had pulmonary embolic disease associated with multiple injuries, and 55 percent of these died within the first 24 hours.

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# Professional Activities



## FEATURES of the 1973 Annual Meeting Ohio State Medical Association Columbus — May 6 - 9



# Choose Your 'Educare' Courses at the OSMA 1973 Annual Meeting

Columbus, May 6-9

Note: Each of the following programs is acceptable for three hours of prescribed credit by the American Academy of Family Physicians.

**T**HERE IS ONE MEETING in particular that physicians should be thinking about at this time, and that is the 1973 Ohio State Medical Association Annual Meeting in Columbus, May 6-9. The Annual Meeting is a composite of continuing medical education programs via postgraduate courses, general sessions, symposia, and exhibits.

This meeting is a once-a-year medical conclave during which Ohio physicians in all fields of practice may find programs to fit their particular likings and needs, with education and patient care Number One on the agenda. The Ohio State Medical Association has adopted "Educare: 1973" as the theme for this medical meeting.

Listed in the following columns are some scientific programs from which physicians may make selections to fit their particular needs and interests.

## TUESDAY, MAY 8, 1973 CHEST PHYSICIANS

9:00 a.m.

Room 206-207, Second Floor  
Veterans Memorial Building

Program sponsored by the Ohio Chapter,  
American College of Chest Physicians.

### PROGRAM

Presiding:

Richard A. Krumholz, M.D.,  
Kettering, Pres., Ohio Chapter,  
American College of Chest  
Physicians.

9:00- 9:40 a.m. **Pulmonary Disability: Occupational Aspects** — Stewart Brooks, M.D., Kettering Institute, Cincinnati.

9:40-10:20 a.m. **Pulmonary Disability: Environmental Aspects** — James Tenenbaum, M.D., Ohio State University School of Medicine, Columbus.

10:20-10:40 a.m. Coffee Break

(Chest Physicians—Contd.)

10:40-11:20 a.m. **Pulmonary Disability: The Chest Physician's View** — William Anderson, M.D., University of Louisville, School of Medicine, Louisville, Ky.

11:20-12:00 Noon Business Meeting

## TUESDAY, MAY 8, 1973 SPORTS MEDICINE

9:00 a.m.

South Terrace, Ground Floor  
Veterans Memorial Building

Program sponsored by the  
OSMA Section on Sports Medicine.

### PROGRAM

Opening Remarks: Sol Maggied, M.D., West Jefferson, Chairman, Section on Sports Medicine and Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association.

9:10 a.m. **Head Injury Incidence**—Richard F. Slager, M.D., Columbus, Instructor, Division of Orthopedic Surgery, Ohio State University.

9:20 a.m. **Available Protective Devices**—John Bozick, Equipment Director, Ohio State University.

9:30 a.m. **The Role of the Neck in Collision Sports**—Alan W. Hart, Head Athletic Trainer, The Ohio State University.

9:40 a.m. **Neck Injury Patient—(Game Plan to Manage—Acutely; When to Return to Game; Value of Cervical Collar)** John N. Meagher, M.D., Associate Professor, Neurological Surgery, Ohio State University.

(Sports Medicine—Contd.)

- 10:00 a.m. **Head Protection in Football—(Brain Tolerance to Impact as Recorded Inside Headgear)**—Stephen E. Reid, M.D., Associate Professor of Surgery, Northwestern University Medical School, Evanston, Illinois.
- 10:40 a.m. **Movie: A Study of Injuries of the Knee Associated with Blocking at the Knee Level**—Thomas R. Peterson, M.D., Ann Arbor, Mich., Orthopaedic Surgeon, Clinical Instructor in Orthopaedic Surgery, University of Michigan Medical Center, member American Orthopaedic Society for Sports Medicine.  
**Recommendation**
- 11:10 a.m. **Reflections and Recommendation—(Neck Strengthening Exercises; “Spear” Blocking; Face Masks; Headgears; and Changing Blocking Techniques)**—W. W. “Woody” Hayes, Head Football Coach, Ohio State University.
- 11:40 a.m. **Summary**—Robert Murphy, M.D., Associate Professor of Medicine, Department of Physical Medicine, Ohio State University.

**TUESDAY, MAY 8, 1973**

**PATHOLOGY**

9:00 a.m.  
(ALL DAY)

Room 201, Second Floor  
Veterans Memorial Building

Program sponsored by the Ohio Society of Pathologists in cooperation with the Section on Pathology of the Ohio State Medical Association.

**PROGRAM**

**“Birth-Defect Syndromes”**

Presiding: Daniel J. Hanson, M.D., President, Ohio Society of Pathologists.

- 9:00 a.m. **Birth-defect Syndrome Diagnosis**  
Ronald G. Davidson, M.D., Chief of Medical Genetics, Children’s Hospital, Buffalo, New York, Professor of Pediatrics, State University of New York at Buffalo.

Stella B. Kontras, M.D., Chief of Genetics, Children’s Hospital, Columbus, Professor of Pediatrics, Ohio State University

(Pathology—Contd.)

- Annemarie Somner, M.D., Assistant Professor of Pediatrics, Ohio State University, Columbus
- 10:00 a.m. **Amniocentesis from the Obstetrician’s Viewpoint**—William C. Rigby, M.D., Associate Professor of Obstetrics and Gynecology, Ohio State University, Columbus.
- 10:30 a.m. Break for Tour of Exhibits
- 10:45 a.m. **Management Responsibility in the Medical Laboratory** (A panel Discussion)
- 11:45 a.m. Business meeting of the Ohio Society of Pathologists
- 12:30 p.m. Lunch
- 2:00 p.m. **Symposium on Amniotic Fluid Studies for Prenatal Detection of Genetic Disorders**—Ronald G. Davidson, M.D., Chief of Medical Genetics, Children’s Hospital, Buffalo, New York, Professor of Pediatrics, State University of New York at Buffalo.
- 3:00 p.m. Break for Tour of Exhibits
- 3:15 p.m. Symposium Continued

**TUESDAY, MAY 8, 1973**

**NEUROLOGY**

1:30 p.m.

Room 208, Second Floor  
Veterans Memorial Building

Program sponsored by the OSMA Section on Neurology.

**PROGRAM**

**“Symposium on Aphasia and Learning Disorders”**

Presiding: Anthony J. Iannone, M.D., Toledo, Chairman, Section on Neurology

- 1:30 p.m. **Aphasia in Clinical Neurology**—D. Frank Benson, M.D., Professor of Neurology, Boston University School of Medicine and Director, Neurobehavioral Section, Boston Veterans Administration Hospital, Boston, Massachusetts.

*(Continued on Next Page)*

(Neurology—Contd.)

- 2:30 p.m. **Learning Disorders of Childhood as Viewed by the Neurologist**—Anthony Iannone, M.D., Professor of Neurology, Medical College of Ohio at Toledo.
- 3:00 p.m. **The PICA Test in Relationship to Developmental Dyslexia**—Earl S. Sherard, Jr., M.D., Professor of Pediatrics (Neurology) and Jean Schuler, Director of Speech Therapy, Ohio State University School of Medicine.
- 4:15 p.m. **Problems of Aphasia in Children**—G. Dean Timmons, M.D., Akron, Pediatric Neurologist, Private Practice.
- 5:00 p.m. **Business Meeting.**

**WEDNESDAY, MAY 9, 1973**

## **RHEUMATOLOGY**

**2:00 p.m.**

**Room 201, Second Floor  
Veterans Memorial Building**

Program sponsored by the Section on Rheumatology and Ohio Rheumatism Society.

### **PROGRAM**

#### **"Laboratory Findings in Rheumatic Diseases"**

Presiding: Vol K. Philips, M.D., Columbus, President, Ohio Rheumatism Society

2:00 p.m. **"Laboratory Findings in Rheumatoid Arthritis"**—Evelyn V. Hess, M.D., Professor of Medicine, Director, Division of Immunology, University of Cincinnati Medical Center, Cincinnati.

2:45 p.m. **"Laboratory and Immunological Findings in Systemic Lupus Erythematosus"**—George J. Friou, M.D., Professor of Medicine, Rheumatic Disease Section, University of Southern California Medical Center, Los Angeles, California.

3:30 p.m. **"Synovial Fluid Findings in Rheumatic Diseases"**—Allan B. Kirsner, M.D., Clinical Assistant Professor of Medicine at the Medical College of Ohio at Toledo, and a member of the Division of Rheumatology of the Toledo Clinic.

*(Continued on Page 293)*

**Santyl<sup>new</sup>**  
**(collagenase)**  
ointment

**Indications:** Santyl Ointment is indicated for debriding dermal ulcers and severely burned areas. In other types of necrotic skin lesions reports on the use of Santyl Ointment have been limited to clinical observations without controls.

**Contraindications:** Application is contraindicated in patients who have shown local or systemic hypersensitivity to Collagenase.

**Precautions:** The enzyme's optimal pH range is 7 to 8. Lower pH conditions have a definite adverse effect on the enzyme's activity, and appropriate precautions should be taken.

The enzymatic activity is also adversely affected by detergents and hexachlorophene and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl Ointment is applied. Soaks containing metal ions or acidic solutions such as Burow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution do not interfere with the activity of the enzyme.

Debilitated patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

The ointment should be confined to the area of the lesion in order to avoid the risk of irritation or maceration of normal skin.

A slight erythema has been noted occasionally in the surrounding tissue particularly when the enzyme ointment was not confined to the lesion. This can be readily controlled by protecting the healthy skin with a material such as Lassar's paste.

Since the enzyme is a protein, sensitization may develop with prolonged use although none has been observed to date.

**Adverse Reactions:** Adverse reactions to Collagenase have not been noted when used as directed.

**Dosage & Administration:** Santyl Ointment should be applied once daily (or once every other day in the case of outpatients) in the following manner.

(1) Prior to application the lesions should be gently cleansed with a gauze pad saturated in normal saline, buffer (pH 7.0-7.5) or hydrogen peroxide to remove any film and digested material.

(2) Whenever infection is present, as evidenced by positive cultures, pus, inflammation or odor, it is desirable to use an appropriate topical antibacterial agent. Neomycin-Bacitracin-Polymyxin B (Neosporin) has been found compatible with Santyl Ointment. This antibiotic should be applied to the lesion in powder form or solution prior to the application of Santyl Ointment. Should the infection not respond, therapy with Santyl Ointment should be discontinued until remission of the infection.

(3) Santyl Ointment should be applied (using a wooden tongue depressor or spatula) directly to deep wounds, or, when dealing with shallow wounds, to a sterile gauze pad which is then applied to wound. The wound is covered with sterile gauze pad and secured with clear tape or Kling bandage.

(4) Crosshatching thick eschar with a #11 blade is helpful. It is also desirable to remove as much loosened detritus as can be done readily with forceps and scissors.

(5) All excess ointment should be removed each time dressing is changed.

(6) Use of the ointment should be terminated when sufficient debridement of necrotic tissue has taken place.

**Overdose:** Action of the enzyme may be stopped, should this be desired, by the application of Burow's solution U.S.P. (pH 3.6-4.4) to the lesion.

**How Supplied:** Santyl Ointment contains 250 units of Collagenase enzyme per gram of white petrolatum U.S.P. The potency assay of Collagenase is based on the digestion of undenatured collagen (from bovine Achilles tendon) at pH 7.2 and 37° C. for 24 hours. The number of peptides cleaved are measured by reaction with ninhydrin. Peptides released by a trypsin digestion control are subtracted. One net Collagenase unit will solubilize ninhydrin reactive material equivalent to 4 micromoles of Leucine.





# <sup>new</sup> Santyl<sup>TM</sup> (collagenase) ointment

"...it may prove to be the drug  
of choice for wound  
debridement."

Varma A. O et al: *Surg. Gynec. Obstet.* 136:281,  
Feb. 1973.

**To permit healing like this...you want to start like this.**



Artist's conception of decubitus ulcer

## **Santyl<sup>TM</sup> (collagenase) for dermal ulcers and burns: the first topical enzyme**

### **► to attack**

native collagen, a substance that is  
ordinarily resistant to all common  
topical enzymes used in wound de-  
bridement

### **► to dissolve**

the strands of tissue that "anchor"  
necrotic debris and burn eschar to  
the wound surface

### **► to effectively remove**

the debris that hinders healing...with  
simple, once-a-day application

I treat patients with dermal ulcers and burns, and I would like  
to receive:

- ☐ clinical reprints and scientific information on Santyl.
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Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritat-

ing symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

# Cold or



# Allergy?

**Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.**

**INDICATIONS:** Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

**CONTRAINDICATIONS:** Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

**WARNINGS:** *Use in children:* In infants

and children particularly, antihistamines in overdosage may produce convulsions and death.

**PRECAUTIONS:** Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants

## Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

such as alcohol, hypnotics, sedatives, tranquilizers, etc.

**ADVERSE REACTIONS:** Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

**HOW SUPPLIED:** Light blue Extentabs in bottles of 100 and 500.

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# when pain goes on... and on... and on—



For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides  $\frac{1}{4}$  grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

## Phenaphen<sup>®</sup> with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital ( $\frac{1}{4}$  gr.), 16.2 mg (warning: may be habit forming); Aspirin ( $2\frac{1}{2}$  gr.), 162.0 mg; Phenacetin (3 gr.), 194.0 mg; Codeine phosphate,  $\frac{1}{4}$  gr (No. 2),  $\frac{1}{2}$  gr (No. 3) or 1 gr (No. 4) (warning: may be habit forming).

**Indications:** Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

Ⓜ Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. **A-H-ROBINS**

(Rheumatology—Contd.)

4:00 p.m. **"Laboratory Findings in Polymyositis, Scleroderma and Related Disorders"**—Vol K. Philips, M.D., Assistant Clinical Professor of Medicine, Ohio State University and the Columbus Medical Center, Columbus.

4:45 p.m. Panel Discussion  
Moderator: Marvin H. Thomas, M.D., Assistant Clinical Professor of Medicine, Ohio State University and the Columbus Medical Center, Columbus.

Panel Participants: Evelyn V. Hess, M.D.; George J. Friou, M.D.; Allan B. Kirsner, M.D. and Vol K. Philips, M.D.

**WEDNESDAY, MAY 9, 1973**  
**OPHTHALMOLOGY**

3:00 p.m.  
Room 206-207, Second Floor  
Veterans Memorial Building

Program sponsored by  
the OSMA Section on Ophthalmology and  
the Ohio Ophthalmological Society.

**PROGRAM**

Presiding: William J. Crawford, M.D., Middletown, Chairman, OSMA Section on Ophthalmology.

3:00 p.m. **"Complications of Strabismus Surgery"**—Ronald L. Price, M.D., Department of Ophthalmology and Pediatrics and Director of Pediatric Ophthalmology, Cleveland Clinic, Cleveland.

3:30 p.m. **"Practical Aspects of Fluorescein Angiography"**—Frederick H. Davidsdorf, M.D., Columbus; Assistant Professor, Department of Ophthalmology, Ohio State University.

(Ophthalmology—Contd.)

4:00 p.m. **"Therapy of Corneal Diseases"**—Richard H. Keates, M.D., Columbus, Professor of Ophthalmology and Director of Corneal Service, Ohio State University.

**TUESDAY, MAY 8, 1973**  
**GENERAL SESSION**

9:00-11:30 a.m.  
Assembly Hall, First Floor  
Veterans Memorial Building

Program sponsored by the  
Ohio State Medical Association,  
Ohio Society of Internal Medicine and the  
Section on Internal Medicine.

**Quality medical care in government—  
Will PSRO Do It?"**

Moderator: William A. Millhon, M.D., Columbus, President, Ohio Society of Internal Medicine

Subjects to be covered:

1. State regulations for quality.
2. AMA approach to quality care.
3. National government approach to quality medical care.
4. Advisory panel for speakers made up for OSIM members.

**- Guest Speakers -**

Richard Wilbur, M.D., Assistant Secretary of Defense for Health and Environment.  
John Cashman, M.D., Director, Ohio Department of Health.  
William I. Bauer, M.D., Greeley, Colorado, PSRO Director, HEW Designee.

**- Advisory Panel -**

Oscar W. Clarke, M.D., Gallipolis  
James M. Garvey, Jr., M.D., Cincinnati  
Robert W. Jones, M.D., Mansfield  
Peter Overstreet, M.D., Toledo

# MAKE YOUR HOTEL RESERVATIONS For The 1973 OSMA Annual Meeting

## COLUMBUS, OHIO

**MAY 6-9**

**Leading Downtown Columbus  
Hotels at Prevailing Rates**

### SHERATON-COLUMBUS MOTOR HOTEL

50 North Third Street  
(OSMA Headquarters)

Singles . . . . . \$19.00 - \$31.00  
Twins . . . . . \$26.00 - \$38.00

### NEIL HOUSE MOTOR HOTEL

41 South High Street  
(OSMA Overflow Hotel)

Singles . . . . . \$14.00 - \$23.00  
Doubles . . . . . \$18.00 - \$28.00  
Twins . . . . . \$19.00 - \$26.00

### SOUTHERN HOTEL

South High and East Main Streets

Singles . . . . . \$12.00 - \$13.00  
Doubles . . . . . \$15.00 - \$16.00  
Twins . . . . . \$15.50 - \$20.00

### CHRISTOPHER INN

300 East Broad Street  
(Woman's Auxiliary Headquarters)

Singles . . . . . \$15.50  
Doubles . . . . . \$20.00  
Twins . . . . . \$23.00

### HOLIDAY INN - DOWNTOWN

175 East Town Street

Singles . . . . . \$15.00  
Doubles . . . . . \$20.00  
Twins . . . . . \$20.00

All rates subject to change. If you plan to share a room, please indicate name of roommate.



## **HOTEL RESERVATION BLANK**

(Mail to Hotel of Choice)

\_\_\_\_\_  
(Name of Hotel)

\_\_\_\_\_  
(Address)

Columbus, Ohio

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 6-9, 1973 (or for period indicated).

\_\_\_\_\_ Single Room

\_\_\_\_\_ Twin Room

\_\_\_\_\_ Double Room

Other Accommodations \_\_\_\_\_

Price Range \_\_\_\_\_

Guaranteed \_\_\_\_\_

Arrival: May \_\_\_\_\_ at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Departure: May \_\_\_\_\_ at \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

**PLEASE VERIFY MY RESERVATION**

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_



OMPAC Proudly Presents...



"The inside-Washington  
comedian without an equal..."

## Mark Russell

Subject:

**"POLITICS IS A LAUGHING  
MATTER"**

**TUESDAY, MAY 8, 1973 — 11:30 A.M.**

(Week of the OSMA Annual Meeting)

**Saturn Room, Second Floor,  
Sheraton-Columbus**



WHAT MARK RUSSELL does is to say salient things about big people, Establishment people and their big institutions . . . things some of us would like to say but don't dare . . . or just aren't bright enough to say them. So, we're happy that Mark says his things so well — even rhymes and sings them. Further, he slices into the absurdities of life so that you can almost abide them. He attacks his topics with zest and glee, tumbling out of his incisive comedic talent. He turns satire into hilarity. You don't feel you've been enlightened by Mark but you KNOW you've been entertained.



**OMPAC LUNCHEON RESERVATION  
TUESDAY, MAY 8, 1973 — 11:30 A.M.**

Enclosed is \$\_\_\_\_\_ to pay for:

\_\_\_\_\_ OMPAC Luncheon tickets @ \$5.00 per person

Name\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_

Make checks payable to the OHIO STATE MEDICAL ASSOCIATION

Mail to: OSMA, 17 South High Street, Suite 500, Columbus, Ohio 43215

# Candidate for the Office of President-Elect

IN ACCORDANCE WITH Section 3 of Chapter 5 of the OSMA Bylaws, the following nomination of a candidate for the office of President-Elect of the Ohio State Medical Association has been filed with the Executive Director 60 days prior to the meeting of the House of Delegates at which the election is to take place:



James L. Henry, M.D.

*Academy of Medicine  
of Columbus and Franklin County*

Columbus, Ohio  
November 3, 1972

Mr. Hart F. Page  
Executive Director  
Ohio State Medical Association  
17 South High Street  
Columbus, Ohio 43215

Dear Mr. Page:

By constitutional privilege, we are pleased to nominate James L. Henry, M.D., Secretary-Treasurer of the Ohio State Medical Association, as a candidate for the office of President-Elect of the Ohio State Medical Association. The Council of the Academy of Medicine of Columbus and Franklin County voted unanimously to support Dr. Henry's nomination.

Doctor James L. Henry is qualified by Active membership in good standing in the Academy of Medicine of Columbus and Franklin County, the Ohio State Medical Association and the American Medical Association.

Respectfully submitted,

Keith DeVoe, Jr., M.D.  
President

## MILITARY SERVICE:

Served on active military duty from July 1945 to 1947; Captain, U.S. Army Medical Corps; served one year as Chief of Out-patient Service at Camp Kilmer, New Jersey

## HOSPITAL APPOINTMENTS AND ACTIVITIES:

Chairman, Department of General Practice, Mt. Carmel Hospital, Columbus, from 1958 to 1970; on Medical Advisory Board of Mt. Carmel Hospital, the Disaster Committee, and served as consultant to the Sisters of Holy Cross (National) during that time; edited the Mt. Carmel Hospital news bulletin.

## Curriculum Vitae

JAMES L. HENRY, M.D.

OFFICE: 250 East Park Street, Grove City

HOME: 244 East Park Street, Grove City

PRACTICE: General practitioner in Grove City area  
from 1948 to present

BIRTHPLACE: Spokane, Washington, Feb. 27, 1919

## EDUCATION AND TRAINING:

- Graduate of Grove City High School, 1937
- Graduate of Ohio State University, B.A. degree, 1942
- Graduate of OSU College of Medicine, 1944
- Internship, St. Francis Hospital, Columbus

## ACADEMY OFFICES AND ACTIVITIES:

- Member, Academy of Medicine of Columbus and Franklin County
- Secretary-Treasurer of Academy, 1954-1958
- Academy President-Elect, 1958
- Academy President, 1959
- Served on a number of committees of the Academy; was chairman of the Utilization Review Committee, Medical Services Committee, and Family Practice Committee; was a member of the Professional Relations Committee, and Academy representative to the Press Code Committee.

(Continued on Next Page)

## OHIO STATE MEDICAL ASSOCIATION:

Treasurer (and later Secretary-Treasurer) of the Ohio State Medical Association from 1967 to present

Served on Peer Review Committee, Building Committee, and numerous other committees while a member of the OSMA Council.

## OTHER ACTIVITIES:

Member of the American Medical Association

Member of the Ohio Academy of Family Physicians and the American Academy of Family Physicians

President of Medical Advances Institute (MAI), which is responsible for developing Professional Standards Review Organizations (PSRO) in Ohio

Published a number of articles on peer review and utilization review

Addressed several national medical conferences and a number of Ohio on peer review and utilization review

## FAMILY:

Married to the former Virginia Hysell in 1942; two children — a son James, and a daughter Diane.

---

# Candidates Sought for Two More OSMA Family Practice Scholarships

Application's for the Ohio State Medical Association's two annual family practice scholarships are now being received, Dr. William R. Schultz, Wooster, OSMA President, recently announced.

"The \$2,000 scholarships are for the purpose of stimulating, among medical students, interest in practicing family medicine in Ohio," Dr. Schultz said.

Candidates are required to be Ohio residents, to have completed their pre-medical education, and to have been accepted by a medical school. Application must be made in the year of entering medical school—but prior to beginning medical studies.

Candidates are judged on the basis of integrity, interest in community activities and orga-

nizations, leadership, intelligence, maturity, scholastic ability, and need.

Administered by the OSMA Family Practice Scholarship Subcommittee, the program pays each recipient from a four-year medical school \$500 annually. Payment dates are arranged with students enrolled in three-year programs. The award is paid directly to the winners.

Application forms may be obtained from the Family Practice Scholarship Subcommittee, Ohio State Medical Association, 17 South High Street, Columbus, Ohio 43215. Completed applications must be in the OSMA offices no later than **June 1, 1973**. Also, all candidates will be required to attend a special luncheon sponsored by the Family Practice Scholarship Subcommittee on **Wednesday, June 13, 1973** in Columbus.

Recipients of the 1972 scholarships were Mrs. Phyllis A. Hutson, Maple Heights, a first-year student at Case Western Reserve School of Medicine, Cleveland, and Carl S. Wehri, Cloverdale, a first-year student at the Ohio State University College of Medicine.

Other medical students currently on OSMA scholarships include Donald M. Miller, Upper Sandusky, Medical College of Ohio at Toledo; Albert J. Weisbrot, Cincinnati, University of Cincinnati College of Medicine; John E. Pappas, Cuyahoga Falls, Temple University School of Medicine; John H. Surry, Youngstown, St. Louis University College of Medicine; and Richard W. Pine, Columbiana, Case Western Reserve University School of Medicine.

This marks the 25th year for the OSMA scholarship program.

# OSMA Group Plan Pays Another Dividend

The Ohio State Medical Association Group Term Insurance Plan earned a 23 percent dividend for 1972, which was returned to participants as a reduction of premium due.

The dividend is the 14th consecutive one paid since the inception of the program in 1958.

Turner & Shepard, Inc., the plan's administrator, reported that the plan's dividends and low net cost are made possible by increasing membership participation in the plan.

The Group Term Plan can be used by professional corporations as a significant employee benefit.



# NIGHT



## AT THE RACES

MAY 8, 1973 - 6:30 P.M.

# SCIOTO DOWNS

## ALL THE THRILLS OF HARNESS RACING . . .

### "OSMA'S NIGHT AT SCIOTO DOWNS"

Scioto Downs, 6000 South High St.

\$12.50 per person (\_\_\_\_\_)   
Number

(Special Price to Exhibitors of \$9.00 per person)

Fill out the ticket form and mail to the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Make checks payable to the Ohio State Medical Association.

Name \_\_\_\_\_

Address \_\_\_\_\_

(Please pick up tickets in your pre-registration envelope at OSMA Registration desk)

# Resolutions Submitted for Consideration

## At the 1973 Annual Meeting

**I**N THE FOLLOWING COLUMNS are texts of a couple resolutions and titles of others scheduled to be presented for consideration by the House of Delegates at the 1973 Annual Meeting of the Ohio State Medical Association, May 6-9, in Columbus. These resolutions were received in the Columbus Office on or before March 7, thereby meeting the 60-day deadline.

No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. Please refer to Chapter 4, Section 8 entitled Resolutions of the Constitution and Bylaws of the Ohio State Medical Association for complete clarification.

Copies of all resolutions presented to the Columbus Office are being sent to the individual delegates and alternate delegates so that they may discuss them with their county medical societies.

### RESOLUTION NO. 1-73

#### Members in Training

(By the Council of the Ohio State Medical Association)

**WHEREAS,** It is desirable to define more accurately the status of those physicians who are pursuing studies and training in accredited programs, and

**WHEREAS,** It is desirable to increase the participation of such physicians in organized medicine, **IT IS HEREBY**

**PROPOSED,** That the Constitution and Bylaws of the Ohio State Medical Association be amended as follows:

### CONSTITUTION

#### ARTICLE III

Section 1. No. 3 Delete "Resident and Intern Members" and insert "Members in Training."

Classes of members

**Section 2. Voting Members.** The voting members of this Association shall consist of each of those physician members of the component societies who has complied with the eligibility requirements of Chapter 1 of the Bylaws of this Association, and who has been certified by the appropriate officer of his component society as being an active member or a **member in training** in good standing of such society, and whose dues and assessments in this Association for the current year have been received at the headquarters of this Association; provided, however, that the foregoing provision regarding receipt of dues and assessments shall not apply to members exempted from the payment of dues and assessments under the provisions of Chapter 2 of the Bylaws of this Association, or to members whose dues and assessments have been waived.

#### ARTICLE VI

**Section 2. Election and Eligibility.** The officers of this Association shall be elected by the House of Delegates during the Annual Meeting. No person shall be eligible for an elective office who has not been (a) an active member or **member in training** of this Association during the entire preceding two years. The terms of the officers of this Association shall be such as are prescribed by Chapter 6 of the Bylaws of this Association.

### BYLAWS

#### CHAPTER I

##### Membership

#### Section 2. Classification of Membership.

(a) **Active Members.** Active Members of this Association shall comprise all the active members in good standing of the several component societies. Active Members in good standing of this Association shall have the right to vote and hold office.

(b) \* \* \*

Delete present (c) and insert:

(c) **Members in Training.** Members in training shall comprise all those members in good standing of the several component societies who are pursuing studies and training in a program accredited by the American Medical Association and its associated groups. Members in training in good standing of this Association shall have the right to vote and hold office.

**Section 3. Eligibility.** Delete "or resident or intern" in first sentence.

#### CHAPTER 4

##### The House of Delegates

**Section 2. Ratio of Representation.** Each component society shall be entitled to one delegate in the House of Delegates for each one hundred (100) Active, Associate Members, and **Members in Training**, or fraction thereof, in good standing in this Association; provided, however, that each component society shall be entitled to at least one delegate and one alternate delegate. The names of such delegates and alternate delegates shall be submitted to the headquarters of this Association at least thirty (30) days prior to the first day of the meeting of the House of Delegates. In case a delegate or alternate delegate of a component society is unable to serve, the president or secretary of such society may at any time certify to the Chairman of the Committee on Credentials the name of an **Active Member** or **Member in Training** in good standing to serve in the place of such absent delegate or absent alternate delegate.

#### CHAPTER 11

##### Membership in Component Societies

**Section 1. Qualifications for Membership in a Component Society.** To be eligible for active membership, associate membership or **in training membership** in a component society, or other probationary or provisional type of membership of limited duration, a person must possess all of the following qualifications:

\* \* \*

Provided, however, that where it is more convenient for a member of a component society to

attend the meetings of another component society located in a county adjoining that in which he holds such membership, such member, upon application to, and approval by, both the society in which he holds such membership and the society in such adjoining county, shall be entitled to a transfer of his membership to the latter society; and, provided further, that no person possessing an active membership, associate membership, or in training membership, or probationary or provisional type of membership, of limited duration, in one component society may acquire or possess at the same time an active membership, or an associate or probationary or provisional type of membership of limited duration, in another component society."

**RESOLUTION NO. 2-73**  
Departments of Family Medicine  
(By the Perry County Medical Society)

**RESOLUTION NO. 3-73**  
Ethics of Charging Interest Rates  
(By the Academy of Medicine of Columbus and Franklin County)

**RESOLUTION NO. 4-73**  
Departments of Family Medicine  
(By the Lorain County Medical Society)

**RESOLUTION NO. 5-73**  
Departments of Family Medicine  
(By the Delaware County Medical Society)

**RESOLUTION NO. 6-73**  
Provider Agreement  
(By the Delaware County Medical Society)

**RESOLUTION NO. 7-73**  
Departments of Family Medicine  
(By the Williams County Medical Society)

**RESOLUTION NO. 8-73**  
Compulsory Formal Postgraduate Education  
(By the Trumbull County Medical Society)

**RESOLUTION NO. 9-73**  
Departments of Family Medicine  
(By the Hardin County Medical Society)

**RESOLUTION NO. 10-73**  
To Authorize Contraceptive and Pregnancy Advice and Treatment for Minors without Parental Consent  
(By the Academy of Medicine of Cleveland)

**RESOLUTION NO. 11-73**  
Emergency Medical Care  
(By the Academy of Medicine of Cleveland)

**RESOLUTION NO. 12-73**  
Departments of Family Medicine  
(By the Academy of Medicine of Cleveland)

**RESOLUTION NO. 13-73**  
Abortion as a Medical Procedure  
(By the Academy of Medicine of Cleveland)

**RESOLUTION NO. 14-73**  
PSRO Sections of P.L. 92-603  
(By the Delaware County Medical Society)

**RESOLUTION NO. 15-73**  
Departments of Family Medicine  
(By the Putnam County Medical Association)

**RESOLUTION NO. 16-73**  
Ohio Department of Public Welfare Regulations  
(By the Ross County Medical Society)

**RESOLUTION NO. 17-73**  
The Ohio Medical Indemnity  
(By the Ross County Medical Society)

**RESOLUTION NO. 18-73**  
Discrimination Against Physicians  
(By the Ross County Medical Society)

**RESOLUTION NO. 19-73**  
Departments of Family Medicine  
(By the Tuscarawas County Medical Society)

**RESOLUTION NO. 20-73**  
Medicine and Religion Academic Curriculum  
(By Richard L. Fulton, M.D., Delegate, Academy of Medicine of Columbus and Franklin County)

**RESOLUTION NO. 21-73**  
Departments of Family Medicine  
(By the Council of the Lake County Medical Society)

**RESOLUTION NO. 22-73**  
Price Control  
(By the Council of the Lake County Medical Society)

**RESOLUTION NO. 23-73**  
Private Practice  
(By the Council of the Lake County Medical Society)

**RESOLUTION NO. 24-73**  
Conflict of Interest  
(By the Council of the Lake County Medical Society)

**RESOLUTION NO. 25-73**  
Confidentiality  
(By the Council of the Lake County Medical Society)

**RESOLUTION NO. 26-73**  
PSRO  
(By the Council of the Lake County Medical Society)

**RESOLUTION NO. 27-73**  
Welfare  
(By the Council of the Lake County Medical Society)

**RESOLUTION NO. 28-73**  
Condemning Euthanasia and the Abuse of the Phrase "Death with Dignity"  
(By Robert C. Atkinson, M.D., Delegate, Academy of Medicine of Columbus and Franklin County)

**RESOLUTION NO. 29-73**  
MAI — PSRO  
(By the Lorain County Medical Society)

**RESOLUTION NO. 30-73**  
Ethical Status of Provider Agreement  
(By the Ross County Medical Society)

**RESOLUTION NO. 31-73**  
Departments of Family Medicine  
(By the Lima and Allen County Academy of Medicine)

**RESOLUTION NO. 32-73**  
Possible Legal Consequences of P.L. 92-603  
(By the Huron County Medical Society)

**RESOLUTION NO. 33-73**  
Deceased Medicare Beneficiaries' Bills to be Paid in Usual and Customary Fashion  
(By the Huron County Medical Society)

**RESOLUTION NO. 34-73**  
Government Controls  
(By the Huron County Medical Society)

**RESOLUTION NO. 35-73**  
Medicare Should Honor 'Itemized' Bill of Deceased  
(By the Huron County Medical Society)

**RESOLUTION NO. 36-73**  
Revenue Sharing and Health and Medical Services  
(By the Huron County Medical Society)

*(Continued on Page 305)*





## acute arthritic inflammation...heat that freezes

In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

## Tandearil® helps take the heat off oxyphenbutazone NF Geigy

Tablets of 100 mg.

**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions.

The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonyleurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
Ardsley, New York 10502

# more than sleep

YOUR CHOICE OF SLEEP MEDICATION  
IS WISELY BASED ON MORE THAN  
SLEEP-INDUCING POTENTIAL

## Sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

## Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane (flurazepam HCl) at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

## Sleep with consistency— no waning of therapeutic effectiveness

Over multiple nights of therapy, no waning of drug effectiveness was noted. There was consequently no need to increase dosage during the study periods. It stands to reason that the fewer repeat or incremental doses needed to sustain sleep, the lower the total cost of the sleep medication. Consistent effectiveness is the measure of Dalmane (flurazepam HCl) economy.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, nonbarbiturate agent proved effective and relatively safe for relief of insomnia.

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(flurazepam HCl)

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One 30-mg capsule *h.s.*—usual adult dosage.

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Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or

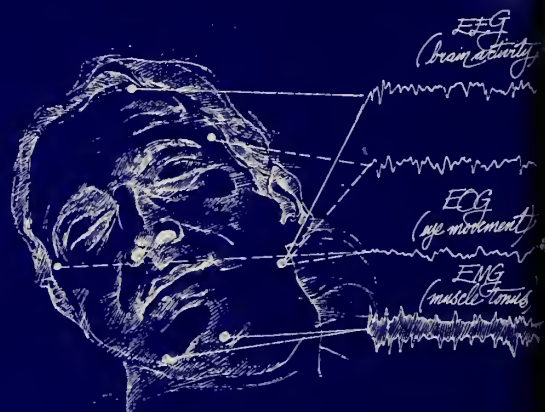
recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years

of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with







nt depression or suicidal tendencies.  
odic blood counts and liver and kid-  
function tests are advised during  
eased therapy. Observe usual precau-  
s in presence of impaired renal or  
atic function.

**Adverse Reactions:** Dizziness, drowsi-  
ness, lightheadedness, staggering, ataxia  
or falling have occurred, particularly  
in elderly or debilitated patients. Severe  
nausea, lethargy, disorientation and  
coma probably indicative of drug intoler-  
ance or overdosage, have been reported.

Also reported were headache, heart-  
burn, upset stomach, nausea, vomiting,  
diarrhea, constipation, GI pain, nervous-  
ness, talkativeness, apprehension, irri-  
tability, weakness, palpitations, chest  
pains, body and joint pains and GU com-  
plaints. There have also been rare occur-  
rences of sweating, flushes, difficulty in  
focusing, blurred vision, burning eyes,  
faintness, hypotension, shortness of  
breath, pruritus, skin rash, dry mouth,  
bitter taste, excessive salivation, anorexia,  
euphoria, depression, slurred speech,

confusion, restlessness, hallucinations,  
and elevated SGOT, SGPT, total and direct  
bilirubins and alkaline phosphatase.  
Paradoxical reactions, e.g., excitement,  
stimulation and hyperactivity, have also  
been reported in rare instances.

**Dosage:** Individualize for maximum bene-  
ficial effect. **Adults:** 30 mg usual dosage;  
15 mg may suffice in some patients.

**Elderly or debilitated patients:** 15 mg  
initially until response is determined.

**Supplied:** Capsules containing 15 mg or  
30 mg flurazepam HCl.



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(Resolutions—Contd.)

**RESOLUTION NO. 37-73**  
**Out-Patient Diagnostic Procedures**  
(By the Huron County Medical Society)

**RESOLUTION NO. 38-73**  
**Insurance Companies Inimical to the  
Private Practice of Medicine**  
(By the Huron County Medical Society)

**RESOLUTION NO. 39-73**  
**Confidentiality of Medical Records Protection Thereof**  
(By the Huron County Medical Society)

**RESOLUTION NO. 40-73**  
**Abortion**  
(By N. M. Camardese, M.D., Delegate, Huron County  
Medical Society)

**RESOLUTION NO. 41-73**  
**Smoking Areas in Some Ohio Schools**  
(By the Madison County Medical Society)

**RESOLUTION NO. 42-73**  
**Departments of Family Medicine**  
(By the Summit County Medical Society)

**RESOLUTION NO. 43-73**  
**Malpractice "Nuisance" Suits**  
(By the Summit County Medical Society)

**RESOLUTION NO. 44-73**  
**Sale of Cigarettes in Hospital Confiness**  
(By the Summit County Medical Society)

**RESOLUTION NO. 45-73**  
**PSRO**  
(By the Summit County Medical Society)

**RESOLUTION NO. 46-73**  
**Medicare Reimbursement**  
(By the Summit County Medical Society)

**RESOLUTION NO. 47-73**  
**Ohio Medical Indemnity, Inc.**  
(By the Council of the Lake County Medical Society)

**RESOLUTION NO. 48-73**  
**PSRO**  
(By the Stark County Medical Society)

**RESOLUTION NO. 49-73**  
**Maternity Hospital Regulations**  
(By the Stark County Medical Society)

**RESOLUTION NO. 50-73**  
**Waiver of OSMA Dues at Age 70**  
(By the Academy of Medicine of Toledo and  
Lucas County)

**RESOLUTION NO. 51-73**  
**Department of General Practice**  
(By the Clermont County Medical Society)

**RESOLUTION NO. 52-73**  
**Abortion**  
(By Michael Anthony, M.D., Delegate, Academy of  
Medicine of Columbus and Franklin County)

**RESOLUTION NO. 53-73**  
**Constitutional Amendment to Protect the Right to Life**  
(By Michael Anthony, M.D., Delegate, Academy of  
Medicine of Columbus and Franklin County)

**RESOLUTION NO. 54-73**  
**PSRO**  
(By the Academy of Medicine of Columbus and  
Franklin County)

**RESOLUTION NO. 55-73**  
**MAI**  
(By the Jefferson County Medical Society)

**RESOLUTION NO. 56-73**

**Life Active Member**  
(By the Council of the Ohio State Medical Association)

WHEREAS, The Ohio State Medical Association is involved in a program of expansion of services and facilities, and

WHEREAS, The financial position of OSMA would be enhanced by a predictable source of capital, thereby negating the necessity of long-term fiscal encumbrances and

WHEREAS, The new Association headquarters represents a possible long-term indebtedness, and

WHEREAS, It is desirable to provide a new classification of members of OSMA to achieve these objectives,

BE IT RESOLVED, That the Bylaws of the Ohio State Medical Association be amended as follows:

In Chapter 1 (Membership), Section 2 (Classification of Membership) insert:

(g) Life Active Members.

Any active member of this Association who shall make a single payment of \$1,250.00 after January 1, 1974, for lifetime membership dues, shall become a Life Active Member of this Association and shall not be assessed additional membership dues during his lifetime. This membership shall be limited to the first 500 active members who make a single lifetime membership dues payment of \$1,250.00 after January 1, 1974.

**RESOLUTION NO. 57-73**  
**Recruitment of Medical Students**  
(By James F. Stewart, M.D., Delegate, Butler  
County Medical Society)

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*(See Page 319)*



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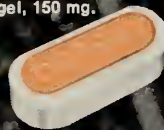
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# Continuing Medical Education Activities of OSMA Members, 1972

OHIO STATE MEDICAL ASSOCIATION COMMISSION  
ON MEDICAL EDUCATION REPORT AND RECOM-  
MENDATIONS TO THE OSMA HOUSE OF  
DELEGATES, 1973, REGARDING SURVEY OF  
CONTINUING EDUCATION ACTIVITIES AND AT-  
TITUDES OF OSMA MEMBERS, WITH CON-  
CLUSIONS AND RECOMMENDATIONS OF THE  
COMMISSION.

## Introduction to Survey Report

"Continuing medical education is defined as educational activities designed to reinforce the physician's basic medical knowledge and inform him of new developments within his field through refresher and supplemental courses. These programs do not lead to any formal, advanced standing in the profession."

—American Medical Association *Topics*, 1972

The survey of the Ohio State Medical Association membership so ably conducted by Commission member Howard S. Madigan, M.D., Toledo, indicates that about 90 percent of the members who answered the questionnaire are involved in continuing medical education (CME) activities other than reading. Ninety-seven percent do read more than an hour a week, and 78 percent read more than two hours a week in addition to those other learning activities.

Those answering the questionnaire represent about 25 percent of our membership. We do not know for certain how representative this is. However, examination of the number of physicians by type of practice in Ohio and examination of Ohio physicians by age groups indicates that our results may be considered significantly representative of the membership of OSMA, both by age and by specialty.

It has been suggested that our sample may be skewed. Was the questionnaire answered only by those who are engaging in CME? One can only conjecture. The respondents did not need to sign their names. Furthermore, the last part of the questionnaire dealt with perspectives for the future and requested members' opinions regarding documentation of CME and whether or not CME should be made compulsory. It is possible, then, that the return might even be skewed in the other direction; those not wishing to be bothered with CME might in fact have answered in greater proportion than those who favored it.

But let us assume, for the purpose of argu-

ment, that the sample is positively skewed; i.e., that those favoring documentation answered in greater proportion than those opposed to it. Then the figures are all the more interesting. Two-thirds of the answering members in private practice voted for **optional** documentation versus **mandatory** documentation. Of those who thought the documentation should be mandatory . . . and this is the crux of the thing as far as our original charge from the House of Delegates is concerned . . . only 19 percent thought that documentation of CME should be a requirement for continuing membership in the OSMA. (That is, 19 percent of the one-third favoring mandatory documentation or approximately 7 percent of the members in private practice who answered the survey).

The members who took the trouble to answer the questionnaire can be supposed to be interested and concerned. Only seven percent of those think that documentation of CME should be made a requirement for continuing membership in the OSMA. It is most unlikely that members who didn't answer the questionnaire would vote in any greater number for CME documentation for continuing membership in the OSMA.

Our own commission members, after two years of debating theoretical pros and cons and educating ourselves regarding national trends, are all dedicated to CME. Most favor some sort of documentation of CME; moreover some of us in the early days of our deliberations favored very strict rules, even to the point of tying compulsory CME to relicensure.

It is obvious from the OSMA membership survey that the Commission members are not alone in being dedicated to the concept of CME; our members are engaging in it in some form voluntarily and in great numbers. But, it is equally obvious that 93 percent of the practicing physicians who answered the survey do not want to have to exhibit evidence of their CME in order to maintain membership in the OSMA. (Somewhat more voted not to require evidence of CME for relicensure).

Your Commission cannot ignore those figures as it sends these recommendations to the House of Delegates. While continuing our dedication to the principle of encouraging CME for all practicing physicians, the Commission strongly feels that we should respect the democratic process. The Commission therefore recommends to the House of Delegates, on the basis of the survey

results, that documentation of CME should not be a requisite for continuing membership in the OSMA, or for relicensure.

Our recommendations do not stop there. We herewith offer positive suggestions regarding what we consider to be the best ways to implement and document CME. Dr. Madigan's comments at the end of his survey are apropos, and are to be considered a part of this report.

We also ask the House of Delegates to address itself to the problem of accreditation of existing and new programs in medical education in Ohio since the AMA no longer will be able to do this at the state or local level. AMA is re-

questing the State Medical Associations to take over the inspection and ultimate accreditation or disapproval of local programs. This could be a task, but some states, California among others, have begun it and OSMA can benefit from their experience. It is probably going to be necessary to establish a director of continuing medical education, not necessarily an M.D. to give counsel to those now conducting or contemplating educational programs at the local level, and to aid in the accreditation of such. The House of Delegates understands that it will be necessary to fund such an office and has approved the principle of full-time staffing of the program.

## Report of Survey of Continuing Medical Education Activities of OSMA Members, 1972

By HOWARD S. MADIGAN, M.D.

Associate Dean for Continuing Education

Medical College of Ohio at Toledo

Member, OSMA Committee on Medical Education

Member, OSMA Commission on Medical Education

PURSUANT TO A RESOLUTION adopted by the House of Delegates at the Annual Meeting of the OSMA in May, 1972, the Commission on Education conducted a survey of OSMA members to determine: (1) their present involvement in continuing education, (2) their opinions and attitudes regarding possible future continuing education policies and practices, with particular attention to minimum requirements and controls. The survey was conducted by means of a questionnaire incorporated in a special OSMAgram, distributed to the membership in mid-July, 1972.

### Material and Methodology

The total response was approximately 2500, representing almost 25% of OSMA members. Of this number, 300 indicated that they were engaged in 'other than private practice.' Thus, in studying the data, attention has been focused on respondents in private practice, a working total of 2161 physicians.

This report presents analysis and tabulation of data compiled from the 'Profile and Prospectus' questionnaires. The information initially was transferred to data processing work sheets and key punched. A series of computer print-outs were

prepared, the data analyzed and tabulated. These are presented in the following sequence:

- I. Characteristics of the Physician Population
- II. Present Activities in Continuing Education
- III. Perspectives for the Future

### I

#### Characteristics of the Physician Population

Characteristics of the 2161 doctors in private practice who comprise the survey population may be identified by considering a series of questions:

(1) Where do the doctors practice? 60% practice in urban locations, 30% in suburban; 10% indicated rural location.

(2) What type of practice arrangement do they have? 60% are in solo practice. Among those in rural locations, 70% are in solo practice. Two-man groups comprised 14% of those in group practice, with 17% in groups of more than three. There was slightly lower incidence of 'more than three' groups among doctors in suburban and rural locations, 12% and 11% respectively.

(3) How many offices do they have? 89% have one office, 8% have two. Only 3% reported having more than two offices. Of those with two

offices, **70%** are in **urban** and **23%** in **suburban** locations.

(4) How many hospital staff appointments do the doctors hold? **Two-thirds** have either **1** or **2** hospital appointments.

(5) How much time (average) do they spend in the office? in hospitals? **80%** spend from **4-6** or **more hours** per day in the office. Of this group, **55%** also spend from **1-4 hours** per day in hospitals.

Understandably, there are variations in response to these questions among specialty groups. The results cited in (1) to (5) above represent the total group.

Education and specialty certification characteristics were identified as follow:

- (1) Medical school attended
- (2) Period in which graduated from medical school
- (3) Specialty board certification
- (1) **Medical school attended** by **1930** doctors (**90%**) reporting are summarized in Table 1.

TABLE 1. Medical School Attended

|                   | Ohio schools | Other U.S. | Foreign    |
|-------------------|--------------|------------|------------|
| All               | 909<br>47%   | 751<br>39% | 246<br>13% |
| Family Practice   | 337<br>61%   | 164<br>30% | 47<br>9%   |
| Internal Medicine | 105<br>43%   | 106<br>43% | 33<br>14%  |
| General Surgery   | 79<br>39%    | 91<br>45%  | 31<br>15%  |
| OB/Gyn            | 48<br>38%    | 54<br>43%  | 23<br>18%  |
| Pediatrics        | 47<br>50%    | 38<br>40%  | 9<br>10%   |

These data reflect the frequent observation that many specialists (other than Family Practice) do not remain in or return to the State in which they went to medical school.

Other data reveal that of the total, **6%** attended medical school in **Pennsylvania**, **5%** in **Illinois** and **3%** in **Michigan**.

(2) The years of graduation from medical school for **2161** doctors are presented in Table 2.

From these data, it may be observed that: (1) **41%** of the doctors are **age 52 or older**; (2) another **43%** are in the age range of **37-51**; (3) only **11%** are **35 years of age or younger**.

Notably, among **family practitioners** and **general surgeons**, **44%** and **50%** respectively are in the **52 or older** category; only **9%** and **6%** respectively are **35 or younger**.

TABLE 2. Year of Graduation for 2161 Doctors

|                   | Not Specified | to '45     | 45-60      | 61-71      | Total |
|-------------------|---------------|------------|------------|------------|-------|
| All               | 92<br>4%      | 889<br>41% | 939<br>43% | 241<br>11% | 2161  |
| Family Practice   | 20<br>3%      | 273<br>44% | 276<br>44% | 53<br>9%   | 622   |
| Internal Medicine | 13<br>5%      | 107<br>40% | 121<br>45% | 27<br>10%  | 268   |
| General Surgery   | 10<br>4%      | 114<br>50% | 88<br>39%  | 14<br>6%   | 226   |
| OB/Gyn            | 9<br>6%       | 58<br>41%  | 54<br>39%  | 19<br>14%  | 140   |
| Pediatrics        | 3<br>3%       | 39<br>36%  | 48<br>44%  | 18<br>17%  | 108   |

(3) Among **2214** doctors in private practice, **51%** were **Board Certified**, including,

|                   |       |       |
|-------------------|-------|-------|
| Family Practice   | — 104 | (17%) |
| Internal Medicine | — 125 | (47%) |
| General Surgery   | — 144 | (64%) |
| OB/Gyn            | — 100 | (71%) |
| Pediatrics        | — 86  | (80%) |

II

Present Activities in Continuing Education

Data pertaining to **reading** as a CME method were provided by **98%** of **2161** doctors, and **two-thirds** reported they **regularly read 3 or more journals**. Overall, only **2%** reported they do not read any journals regularly.

Complete Journal Reading

There were **19%** who indicated they **read two journals completely**; **13%** read **one completely**; **16%** read **three or more completely**. No significant differences occurred among the specialties within each group. Twenty-six percent (**26%**) of doctors reported that they do not read any journals completely, and **25%** did not respond to the question.

In-Depth Journal Reading

Approximately **70%** (**1537**) responded to this question, and **42%** of them indicated they read **three or more journals in-depth**; **37%** read **two journals in-depth**, and **17%** read only one journal in-depth. There were **60** physicians (**4%**) who indicated they read **no journals in-depth**. Of these, **28** (**47%**) were in family practice.

Scanning of Journals

Only **60%** (**1300**) of doctors responded to this question. Among these, **73%** scan **three or more journals**, including **74%** of the group of



family practitioners. Scanning 3 or more was used much less frequently by doctors in other major specialties (32-43%). There were 20% reporting they scan two journals, 9% scan only one journal. Twenty-three (23) doctors, (1.8%) indicated they scan no journals.

Clip, Copy, Take Notes from Journals

A high percentage (91%) responded to this question, and 50% indicated they frequently use this method of CME. Another 38% occasionally do so, while 12% never do. Among family practitioners, 42% frequently and 43% occasionally use this method. Highest indication of frequent use was by pediatricians, 59%.

Other Reading Sources (e.g. monographs, series publications, texts, "throw-away" periodicals)

Among 91% of doctors responding to this question, 40% reported regularly using this method, and 49% frequently use it. Use was comparable among the major specialties. Less than 1% reported never using other reading sources.

Approximately 40% of doctors devote 2-4 hours per week to professional reading. An additional 37% spend 4 or more hours reading. Only 2% reported less than 1 hour of reading per week. Internists had the highest percentage (46%) of reading 4 or more hours; pediatricians the highest (53%) in the 2-4 hour category. Table 3 details the data for average number of hours of professional reading per week.

Fifty percent (50%) of 2161 doctors specified some use of tape recordings as a method of CME. Overall, about one-half of them use the method less than 1 hour per week. Utilization by the major specialties is comparable, as well as the number of hours per week. The data on average hours use per week for the 1074 doctors reporting are in Table 4.

TABLE 4. Use of Tape Recordings as a CME method by physicians in private practice  
N = 2161 There were 1087 (50%) of doctors who indicated that they did not use tape recordings.  
N = 1074

|                   | Average hours used per week |            |           |          | Total       |
|-------------------|-----------------------------|------------|-----------|----------|-------------|
|                   | < 1                         | 1-2        | 2-4       | 4 or 4+  |             |
| All               | 557<br>52%                  | 385<br>36% | 100<br>9% | 32<br>3% | 1074<br>50% |
| Family Practice   | 148<br>47%                  | 118<br>37% | 37<br>12% | 15<br>5% | 318<br>51%  |
| Internal Medicine | 79<br>51%                   | 54<br>35%  | 16<br>10% | 5<br>3%  | 154<br>57%  |
| General Surgery   | 48<br>42%                   | 50<br>43%  | 14<br>12% | 3<br>3%  | 115<br>51%  |
| OB/Gyn            | 41<br>56%                   | 29<br>40%  | 3<br>4%   | 0<br>—   | 73<br>52%   |
| Pediatrics        | 23<br>43%                   | 25<br>46%  | 5<br>9%   | 1<br>2%  | 54<br>50%   |

In the total group (1074), 40% listen to tapes at home, 18% while driving in their car, and 16% combine home and car listening sites. Office and hospital were cited by 6% and 8% as the locale. Family practitioners exhibit similar listening patterns, viz. home, 40%; car 21%; home/car, 15%. There was comparably low incidence of listening to tapes in the office or at hospital among the major specialties.

A total of 456 doctors, 21%, recorded some use of the OSU Continuing Education Radio Network, of whom 80% indicated they had listened to 15 or fewer programs in the past year. Effectiveness of this CME method was considered 'moderate' by 50%, 'slight' by 29%; 16% rated it 'very effective'.

Utilization of radio as a CME method, and rating of its effectiveness by specialty groups are shown in Table 5.

Colleague consultation and hospital conferences were used regularly or frequently by 90% and 88% of all doctors. There was good correlation among the several specialties, as shown in Tables 7 and 8.

Twenty-eight percent (28%) of Family Practitioners were users of radio, and the same percentage listened to 15 or more programs in a year.

TABLE 3. Average number of hours of professional reading per week by physicians in private practice (2161 Doctors)

|                   | < 1      | 1-2        | 2-4        | 4 or 4+    | Total       |
|-------------------|----------|------------|------------|------------|-------------|
| All               | 48<br>2% | 377<br>19% | 809<br>41% | 733<br>37% | 1967<br>91% |
| Family Practice   | 18<br>3% | 132<br>23% | 238<br>42% | 178<br>31% | 566<br>91%  |
| Internal Medicine | 6<br>2%  | 40<br>16%  | 87<br>36%  | 112<br>46% | 245<br>91%  |
| General Surgery   | 5<br>2%  | 38<br>18%  | 97<br>47%  | 67<br>32%  | 207<br>92%  |
| OB/Gyn            | 6<br>5%  | 34<br>26%  | 54<br>42%  | 35<br>27%  | 129<br>92%  |
| Pediatrics        | 2<br>2%  | 15<br>16%  | 51<br>53%  | 28<br>29%  | 96<br>89%   |

A high percentage, 94%, of doctors consider reading to be a 'very' or 'moderately' effective CME method. About 45% of internists and pediatricians consider reading to be very effective; 57% of family practitioners and 62% of obstetricians consider it to be moderately effective. Only 6% of doctors indicated reading as slightly effective, and less than 1% consider it not effective as a CME method.

The method was considered ‘very’ effective by 21%, ‘moderately’ by 56%. Use of radio totalled approximately 20% among the other specialty groups listed, and 81% of them listened to 15 or fewer programs in the year. Rating of effectiveness

varied among the specialties and the small numbers do not make percentages meaningful.

Overall use of television as a CME method was 305 of 2161 doctors, or 14%. Use and rating of effectiveness are tabulated in Table 6.

TABLE 5. Utilization of Radio

|                   | NUMBER OF PROGRAMS HEARD |             |             |            | EFFECTIVENESS |             |             |           | Total |
|-------------------|--------------------------|-------------|-------------|------------|---------------|-------------|-------------|-----------|-------|
|                   | 5 or less                | 5-15        | 15-30       | 30 or more | Very          | Moderate    | Slight      | None      |       |
| Family Practice   | 62<br>(35%)              | 66<br>(37%) | 42<br>(24%) | 7<br>(4%)  | 37<br>(21%)   | 99<br>(56%) | 36<br>(20%) | 5<br>(3%) | 177   |
| Internal Medicine | 17                       | 21          | 8           | 2          | 16            | 17          | 15          | 0         | 48    |
| General Surgery   | 30                       | 22          | 9           | 4          | 6             | 33          | 22          | 4         | 65    |
| Ob/Gyn            | 17                       | 9           | 1           | 2          | 4             | 12          | 9           | 4         | 29    |
| Pediatrics        | 5                        | 8           | 4           | 0          | 2             | 13          | 2           | 0         | 17    |

TABLE 6. Use and Effectiveness of TV as a Continuing Education Method by Physicians in Private Practice

| N=2161            | CCTV       | TYPE NCME  | OTHER     | EFFECTIVENESS |            |           |         | TOTAL      |
|-------------------|------------|------------|-----------|---------------|------------|-----------|---------|------------|
|                   |            |            |           | VERY          | MODERATELY | SLIGHTLY  | 0       |            |
| All               | 135<br>44% | 133<br>44% | 37<br>12% | 57<br>19%     | 153<br>50% | 91<br>30% | 4<br>1% | 305<br>14% |
| Family Practice   | 30         | 42         | 10        | 19            | 44         | 18        | 1       | 82         |
| Internal Medicine | 29         | 20         | 3         | 10            | 24         | 18        | 0       | 52         |
| General Surgery   | 22         | 18         | 4         | 4             | 24         | 16        | 0       | 44         |
| Ob/Gyn            | 7          | 6          | 3         | 5             | 6          | 5         | 0       | 16         |
| Pediatrics        | 7          | 2          | 2         | 1             | 4          | 6         | 0       | 11         |

TABLE 7. Colleague Consultation

|                   | Regularly   | Frequently | % Regularly and Frequently | Occasionally | Never    | Not available |
|-------------------|-------------|------------|----------------------------|--------------|----------|---------------|
| All               | 1032<br>52% | 749<br>38% | 90%                        | 170<br>9%    | 24<br>1% | 13<br><1%     |
| Family Practice   | 305<br>52%  | 233<br>40% | 92%                        | 35<br>6%     | 6<br>1%  | 4<br><1%      |
| Internal Medicine | 124<br>49%  | 107<br>43% | 92%                        | 18<br>7%     | 1<br><1% | 1<br><1%      |
| General Surgery   | 102<br>51%  | 84<br>42%  | 93%                        | 13<br>6%     | 0        | 2<br>1%       |
| OB/Gyn            | 60<br>46%   | 56<br>43%  | 89%                        | 15<br>11%    | 0        | 0             |
| Pediatrics        | 44<br>43%   | 45<br>44%  | 87%                        | 11<br>11%    | 2<br>2%  | 1<br>1%       |

TABLE 8. Hospital Conferences

|                   | Regularly   | Frequently | % Regularly and Frequently | Occasionally | Never    | Not Available |
|-------------------|-------------|------------|----------------------------|--------------|----------|---------------|
| All               | 1145<br>55% | 676<br>33% | 88%                        | 326<br>16%   | 48<br>2% | 55<br>3%      |
| Family Practice   | 244<br>41%  | 223<br>38% | 79%                        | 97<br>16%    | 7<br>1%  | 19<br>3%      |
| Internal Medicine | 159<br>60%  | 77<br>29%  | 89%                        | 26<br>10%    | 1<br><1% | 1<br><1%      |
| General Surgery   | 141<br>65%  | 53<br>24%  | 89%                        | 19<br>9%     | 1<br><1% | 4<br>2%       |
| OB/Gyn            | 71<br>51%   | 49<br>35%  | 86%                        | 18<br>13%    | 1<br><1% | 0             |
| Pediatrics        | 49<br>46%   | 34<br>32%  | 78%                        | 19<br>18%    | 3<br>3%  | 2<br>2%       |

TABLE 9. Use of Attendance/Participation CME Methods by Physicians in private practice  
2161 Doctors

| WARD ROUNDS       | Regularly  | Frequently | Occasionally | Never      | Not Available | Total       |
|-------------------|------------|------------|--------------|------------|---------------|-------------|
| All               | 450<br>24% | 277<br>15% | 442<br>24%   | 303<br>16% | 368<br>20%    | 1840<br>85% |
| Family Practice   | 46<br>9%   | 47<br>9%   | 132<br>26%   | 115<br>23% | 169<br>33%    | 509<br>82%  |
| Internal Medicine | 85<br>35%  | 58<br>24%  | 58<br>24%    | 17<br>7%   | 26<br>11%     | 244<br>91%  |
| General Surgery   | 81<br>40%  | 45<br>22%  | 33<br>16%    | 10<br>5%   | 33<br>16%     | 202<br>89%  |
| OB/Gyn            | 50<br>38%  | 22<br>17%  | 26<br>20%    | 16<br>12%  | 18<br>14%     | 132<br>94%  |
| Pediatrics        | 26<br>27%  | 17<br>17%  | 27<br>28%    | 11<br>11%  | 17<br>17%     | 98<br>91%   |

TABLE 10. Use of Attendance/Participation CME Methods by physicians in private practice  
(N=2161)—Group Discussion, Seminars

|                   | Regularly  | Frequently | Occasionally | Never     | Not Available | Total       |
|-------------------|------------|------------|--------------|-----------|---------------|-------------|
| All               | 376<br>20% | 601<br>31% | 655<br>34%   | 107<br>6% | 177<br>9%     | 1916<br>89% |
| Family Practice   | 59<br>11%  | 156<br>29% | 214<br>40%   | 39<br>7%  | 66<br>12%     | 534<br>86%  |
| Internal Medicine | 43<br>17%  | 83<br>34%  | 85<br>35%    | 16<br>7%  | 19<br>8%      | 246<br>92%  |
| General Surgery   | 50<br>25%  | 68<br>33%  | 62<br>30%    | 7<br>3%   | 17<br>8%      | 204<br>90%  |
| OB/Gyn            | 25<br>20%  | 49<br>38%  | 38<br>30%    | 3<br>2%   | 13<br>10%     | 128<br>91%  |
| Pediatrics        | 14<br>14%  | 27<br>27%  | 45<br>45%    | 5<br>5%   | 9<br>9%       | 100<br>93%  |

Ward rounds as a participation method of CME was used by 85% overall. Regular or frequent use of this method by family practitioners was substantially lower (9% for each) than for other major specialties. Significantly, this modality was recorded as 'not available' by one-third of family practitioners. Data on the use of ward rounds are presented in Table 9.

Seminars or group discussions were utilized by almost 90% of doctors, including 86% of family practitioners of whom 30% indicated frequent use. Regular use was highest among general surgeons; frequent use highest among obstetricians/gynecologists. This modality was recorded as 'not available' by only 9%. The data are summarized in Table 10.

Lectures, panels, symposia and courses, sponsored by different groups, viz., county medical societies, State medical society, American Medical Association, medical schools, specialty groups (ACP, AAFP, ACS) and others, are utilized to a variable extent. Significant data from these tabulations are listed as follow:

- (1) Occasional use of county medical society—40%

TABLE 11. Obstacles to Effective Continuing Education, in Order of Significance, Cited by All Specialties

|  |     |
|--|-----|
| 1. Insufficient time due to patient care load                    | 50% |
| 2. Content of programs not relevant to physicians' practice      | 45% |
| 3. Too much time required travelling to and from program site    | 37% |
| 4. Quality of available programs, courses etc.                   | 30% |
| 5. Lack of available programs, courses, etc.                     | 24% |
| 6. Programs and courses are too expensive for the value received | 20% |
| 7. Insufficient useable information                              | 19% |
| 8. Too tired   | 16% |
| 9. Other factors   | 9%  |

- (2) Never use county medical society—12%
- (3) Lowest occasional use of county medical society, by family practitioners, (37%).
- (4) Overall, one-third never use State Medical Society; includes Internal Medicine 42%, OB/Gyn. 38%, Pediatrics 56%; 26% of family practitioners.
- (5) Overall, 17% regularly or frequently use State Medical Society; includes 5-10%



TABLE 12. Obstacle: Insufficient time due to patient care load

|                   | 1   | Rank<br>2 | 3  | Did<br>Not<br>Rank | Total | Percent |
|-------------------|-----|-----------|----|--------------------|-------|---------|
| All specialties   | 501 | 193       | 98 | 283                | 1075  | 50%     |
| Family Practice   | 199 | 50        | 26 | 95                 | 370   | 59%     |
| Internal Medicine | 81  | 24        | 13 | 45                 | 163   | 61%     |
| General Surgery   | 52  | 21        | 8  | 34                 | 115   | 51%     |
| OB/Gyn            | 26  | 15        | 7  | 23                 | 71    | 51%     |
| Pediatrics        | 19  | 11        | 12 | 9                  | 51    | 47%     |

TABLE 13. Obstacle: Content of Programs not Relevant to Physician's Practice

|                   | 1   | Rank<br>2 | 3   | Did<br>Not<br>Rank | Total | Percent |
|-------------------|-----|-----------|-----|--------------------|-------|---------|
| All specialties   | 364 | 179       | 221 | 218                | 982   | 45%     |
| Family Practice   | 71  | 64        | 68  | 51                 | 254   | 41%     |
| Internal Medicine | 19  | 22        | 28  | 18                 | 87    | 32%     |
| General Surgery   | 35  | 21        | 23  | 24                 | 103   | 46%     |
| OB/Gyn            | 27  | 13        | 21  | 16                 | 77    | 55%     |
| Pediatrics        | 27  | 6         | 7   | 6                  | 46    | 43%     |

TABLE 14. Obstacle: Too much time required travelling to and from program site

|                   | 1   | Rank<br>2 | 3   | Did<br>Not<br>Rank | Total | Percent |
|-------------------|-----|-----------|-----|--------------------|-------|---------|
| All specialties   | 181 | 250       | 140 | 228                | 799   | 37%     |
| Family Practice   | 55  | 90        | 39  | 58                 | 242   | 39%     |
| Internal Medicine | 17  | 34        | 16  | 28                 | 95    | 35%     |
| General Surgery   | 22  | 28        | 14  | 22                 | 86    | 38%     |
| OB/Gyn            | 8   | 17        | 11  | 22                 | 58    | 41%     |
| Pediatrics        | 12  | 19        | 11  | 8                  | 50    | 46%     |

TABLE 15. Obstacle: Quality of available programs, courses etc.

|                   | 1   | Rank<br>2 | 3   | Did<br>Not<br>Rank | Total | Percent |
|-------------------|-----|-----------|-----|--------------------|-------|---------|
| All specialties   | 119 | 238       | 172 | 127                | 656   | 30%     |
| Family Practice   | 36  | 62        | 47  | 35                 | 180   | 29%     |
| Internal Medicine | 17  | 23        | 21  | 19                 | 80    | 30%     |
| General Surgery   | 12  | 24        | 21  | 17                 | 74    | 33%     |
| OB/Gyn            | 10  | 16        | 9   | 11                 | 46    | 33%     |
| Pediatrics        | 5   | 17        | 13  | 2                  | 37    | 34%     |

TABLE 16. Obstacle: Lack of available programs, courses, etc.

|                   | 1   | Rank<br>2 | 3   | Did<br>Not<br>Rank | Total | Percent |
|-------------------|-----|-----------|-----|--------------------|-------|---------|
| All specialties   | 107 | 114       | 202 | 102                | 525   | 24%     |
| Family Practice   | 39  | 28        | 54  | 25                 | 146   | 23%     |
| Internal Medicine | 13  | 9         | 22  | 15                 | 58    | 22%     |
| General Surgery   | 9   | 13        | 19  | 9                  | 50    | 22%     |
| OB/Gyn            | 8   | 9         | 13  | 8                  | 38    | 27%     |
| Pediatrics        | 2   | 6         | 14  | 1                  | 23    | 21%     |

TABLE 17. Obstacle: Programs and courses are too expensive for the value received

|                   | 1  | Rank<br>2 | 3   | Did<br>Not<br>Rank | Total | Percent |
|-------------------|----|-----------|-----|--------------------|-------|---------|
| All specialties   | 65 | 93        | 134 | 132                | 424   | 20%     |
| Family Practice   | 21 | 24        | 47  | 32                 | 124   | 20%     |
| Internal Medicine | 8  | 14        | 12  | 19                 | 53    | 20%     |
| General Surgery   | 4  | 8         | 14  | 20                 | 46    | 20%     |
| OB/Gyn            | 4  | 4         | 7   | 7                  | 22    | 16%     |
| Pediatrics        | 4  | 8         | 3   | 7                  | 22    | 20%     |

TABLE 18. Obstacle: Insufficient useable information

|                   | 1  | Rank<br>2 | 3   | Did<br>Not<br>Rank | Total | Percent |
|-------------------|----|-----------|-----|--------------------|-------|---------|
| All specialties   | 53 | 125       | 125 | 113                | 416   | 19%     |
| Family Practice   | 5  | 39        | 45  | 36                 | 125   | 20%     |
| Internal Medicine | 8  | 14        | 16  | 12                 | 50    | 19%     |
| General Surgery   | 7  | 7         | 12  | 12                 | 38    | 17%     |
| OB/Gyn            | 6  | 13        | 8   | 7                  | 34    | 24%     |
| Pediatrics        | 6  | 7         | 6   | 4                  | 23    | 21%     |

TABLE 19. Obstacle: Too tired

|                   | 1  | Rank<br>2 | 3   | Did<br>Not<br>Rank | Total | Percent |
|-------------------|----|-----------|-----|--------------------|-------|---------|
| All specialties   | 31 | 87        | 107 | 125                | 350   | 16%     |
| Family Practice   | 8  | 28        | 35  | 45                 | 116   | 19%     |
| Internal Medicine | 7  | 18        | 18  | 15                 | 58    | 22%     |
| General Surgery   | 6  | 8         | 9   | 15                 | 38    | 17%     |
| OB/Gyn            | 1  | 1         | 8   | 5                  | 15    | 11%     |
| Pediatrics        | 5  | 1         | 7   | 3                  | 16    | 15%     |

among internists, pediatricians and obstetricians

- (6) **One-half** of family practitioners occasionally use State Society, while about one-fourth regularly or frequently use OSMA
- (7) **AMA-sponsored** activities are used regularly or frequently by 17%, occasionally by 45%; never by 37%. Similar utilization was reported among the specialty groups. Response was made to this item by 70% of 2161 doctors.
- (8) **Medical school-sponsored** activities are used regularly or frequently by 29%, occasionally by 41%; never used by 20%.
- (9) **'Never use'** medical school was reported by 26% of family practitioners, 27% of obstetricians.
- (10) Medical school reported **'not available'** by 9%; including OB/Gyn 15%, General Surgery 12%.
- (11) Among family practitioners, 54% reported regular or frequent use of AAFP-sponsored programs; 22% occasional use;

21%, never. Some Internists and obstetricians reported occasional use of AAFP programs.

- (12) Internists reported 50% regular use, 29% occasional use of American College of Physicians programs; 20% 'never use'. Some family practitioners and obstetricians reported occasional use of ACP programs.
- (13) General surgeons (174/226, 77%) reported 82% regular or frequent use of American College of Surgeons-sponsored activities; 15% occasional use; 6% never use. A few family practitioners and some obstetricians reported occasional use.
- (14) **One-half** of all respondents indicated some use of these modalities sponsored by 'other groups/organizations'. In this category, regular or frequent use was reported by 90%; occasional use by 7%.

Physicians were asked to rank several obstacles to continuing education, in order of their significance. The summary tabulation is shown in Table 11.

The series of eight Tables (12-19) presents an analysis of the **ranking of each obstacle**. Most significant figures in each Table are bold. It should be noted that many doctors specified an obstacle, but did not rank it. These numbers are included in the total who cited a particular obstacle.

III  
Perspectives for the Future

The assumption was stated: "some method by which physicians can document their participation in various CME activities appears to be a near-future, nationwide necessity." The question was posed: "If so, which **ONE** of the following groups would **YOU** prefer to have responsibility for implementing the documentation procedure and 'approving' or 'accrediting' physicians' continuing education activities?" The preferences expressed are presented in Table 20.

It is noteworthy that the OSMA Commission

on Education, medical schools and the State Medical Board were significantly lower among the preferences. However, the 13% overall preference for a consortium/council and a 10% preference for the OSMA Commission suggests that some combined effort may be feasible.

Of approximately 2000 physicians in private practice, **30% agree** that medical schools should assume **primary** responsibility for identifying needs, planning and evaluation of CME. Among this number, **78%** also agree that a minimum number of hours of CME should be prescribed.

There were 1400 doctors who **disagree** that the medical schools should have the responsibility. Among this number, **63% agree** that a minimum number of hours of CME should be prescribed.

These data are summarized in Table 21.

Thus, **67%** of doctors **agree** that a minimum number of hours of CME should be prescribed.

Interestingly, **80%** of doctors who **do not** want a minimum number of hours prescribed, also

TABLE 20. Physicians' preference for group/organization to have responsibility for implementing a CME documentation procedure, and approving/accrediting CME activities (N=2161)

|                                 | ALL        | F.P.       | I.M.       | G.S. | OB/GYN     | PEDS.      |
|---------------------------------|------------|------------|------------|------|------------|------------|
| Hospital(s) in community        | 17%        | 18%        | <b>23%</b> | 21%  | 23%        | 14%        |
| County medical society          | 21%        | <b>27%</b> | 22%        | 22%  | 17%        | 18%        |
| OSMA (Comm. on Educ.)           | 10%        | 14%        | 9%         | 10%  | 8%         | 7%         |
| Medical school in area          | 4%         | 3%         | 6%         | 5%   | 1%         | 6%         |
| Specialty board or organization | <b>26%</b> | 15%        | 10%        | 21%  | <b>34%</b> | <b>28%</b> |
| State Medical Board             | 2%         | 3%         | 3%         | 2%   | 3%         | 2%         |
| Consortium/council of above     | 13%        | 10%        | 19%        | 11%  | 11%        | 17%        |
| None of above                   | 3%         | 3%         | 2%         | 3%   | 3%         | 5%         |
| Other                           | 1%         | 1%         | 1%         | 1%   | 0          | 1%         |

TABLE 21

|   |       |  |                          |
|---|-------|--|--------------------------|
| A. Practicing Physicians' Preference of Base of Responsibility for Identifying Needs, Planning and Evaluating CME |       | Agree  | Disagree                 |
| Medical School  | Total | 589 (30%)                                      | 1393 (70%)               |
|   | G.P.  | 166  | 407                      |
| B. Practicing Physicians who Agree with A: Reaction to Prescribed Minimum Number of Hours of CME                  |       | A minimum number of hours should be            | should not be            |
|   | Total | 459  | 130                      |
|   |       | (78%)  | (22%)                    |
|   | G.P.  | 140  | 24                       |
| C. Practicing Physicians who Disagree with A: Reaction to Prescribed Minimum Number of Hours of CME               |       | A minimum number of hours Should be prescribed | Should not be prescribed |
|   | Total | 866  | 519                      |
|   |       | (62.5%)  | (37.5%)                  |
|   | G.P.  | 288  | 113                      |



TABLE 22. Preference for groups/organizations to have *primary* responsibility for CME.

|                       |   |
|-----------------------|---|
| All respondents       | 1 — specialty organizations<br>2 — specialty boards<br>3 — county medical societies |
| Family Practice       | specialty organization (36%)  |
| Internal Medicine     | county medical societies (28%)  |
| General Surgery       | county medical societies (28%)  |
| Obstetrics/Gynecology | specialty board (33%)   |
| Pediatrics            | 1 — county medical societies (30%)<br>2 — specialty board (28%)                     |

do not prefer that the medical schools have primary responsibility for CME.

Doctors who disagree that the medical schools should have the primary CME responsibility prefer other groups/organizations, as follow in Table 22.

The OSMA, through the Commission on Education, was the preference of 17% overall.

There were 1961 doctors in private practice who responded to the question whether documentation of CME should be mandatory or optional.

35% indicated that documentation should be mandatory.

65% preferred documentation to be optional.

There was some variation among specialty groups, as shown in Table 23.

TABLE 23. Documentation of CME Activity by Physicians Should Be:

|                   | MANDATORY | OPTIONAL |
|-------------------|-----------|----------|
| All Specialties   | 35%       | 65%      |
| Family Practice   | 37%       | 63%      |
| Internal Medicine | 41%       | 59%      |
| General Surgery   | 32%       | 68%      |
| OB/Gyn            | 35%       | 65%      |
| Pediatrics        | 41%       | 59%      |

Doctors who stated that documentation should be mandatory also indicated that it should be a requirement for specific professional activities, as follows:

|  |     |
|--|-----|
| Hospital staff appointment(s)                    | 42% |
| Continued specialty certification                | 30% |
| Continued membership in professional association | 25% |
| OSMA membership                                  | 19% |
| Medical relicensure                              | 17% |
| None of the above                                | 18% |

A majority of doctors in private practice agree that a minimum number of hours of recognized or approved CME activity should be prescribed, as follows:

|                       |     |
|-----------------------|-----|
| All specialties       | 67% |
| Family Practice       | 76% |
| Internal Medicine     | 63% |
| General Surgery       | 70% |
| Obstetrics/Gynecology | 64% |
| Pediatrics            | 64% |

Indications from these doctors as to the number of hours per year that should be prescribed are presented in Table 24.

TABLE 24. The Prescribed Minimum Number of Hours of CME Activity Should Be:

|                   | 50  | 100 | 150 or More |
|-------------------|-----|-----|-------------|
| All Specialties   | 74% | 21% | 5%          |
| Family Medicine   | 87% | 10% | 3%          |
| Internal Medicine | 72% | 25% | 3%          |
| General Surgery   | 68% | 25% | 7%          |
| OB/Gyn            | 68% | 26% | 6%          |
| Pediatrics        | 69% | 25% | 6%          |

### Comment

The data in this Report must be interpreted with circumspection. The total number of respondents represented approximately 25% of OSMA membership. We do not know how many of these doctors are at one extreme or the other with respect to present activity, attitudes or opinions about continuing education; nor their perspectives for the future. Further, we do not know the extent to which their responses have been conditioned during their years of practice.

It seems reasonable, however, to accept the data as a valid sample from which to derive some indication of doctors' thinking about continuing education. The information can be used as one

guide in approaching the future of continuing education for Ohio physicians.

Several possible courses of action deserve consideration by the OSMA House of Delegates, OSMA Commission on Education and other medical education leaders throughout the State:

**First**, there must be effective, responsible leadership provided for the practicing physician. This implies that directors of medical education and other types of education directors become more proficient as educators, rather than program coordinators or managers. Also, there is need to instill more **education**, i.e. teaching/learning methodology, into continuing education. There is a continual need to stimulate doctors' motivation toward continuing education.

**Secondly**, the obstacles to continuing education cited in the survey, and others encountered in local situations, should be overcome whenever possible, primarily through the efforts of education directors. Several obstacles, e.g., relevancy to practice, content, quality, travel time, can be overcome or greatly diminished.

If we are to have a favorable influence on continuing education in the future, effort must be expended to achieve **efficiency, effectiveness** and **economy** for the doctor.

**Third**, it appears evident that **positive action** must be forthcoming in the near future by State as well as county medical societies, in the direction of exercising surveillance of physician continuing education. There are several approaches available, as suggested by the survey data.

**Finally**, efforts can and should be made to broaden the scope of what can be considered **acceptable continuing education activity**, to include individual study, self-assessment and other

activities not now recognized or 'approved'. This should lead to a practical method of **documentation** of continuing education activity.

It will become increasingly necessary to show evidence that we are striving to achieve quality patient care through quality continuing medical education.

(The assistance of Mr. Ramesh R. Parekh, of the Biomedical Computer Laboratory, Medical College of Ohio, is gratefully acknowledged.)

\* \* \*

### Basic Recommendations of the Commission on Medical Education to the House of Delegates

Based on the material contained in this study and report, it is the unanimous recommendation of the Commission on Medical Education that:

1. On the basis of the 1972 membership survey, documentation of continuing medical education should not be made mandatory for membership in OSMA.
2. The Ohio State Medical Association develop a method of recognizing the continuing medical education activities of its members.
3. The method should recognize multiple continuing medical education activities.
4. Continuing medical education activities should be accredited under a system established or approved by the Commission on Medical Education.
5. Implementation of this program may require a dues increase.

Respectfully submitted,  
John G. Sholl, M.D., Chairman  
Commission on Medical Education  
for the Members of the Commission

# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

COMING UP — the thirty-third annual convention of the Woman's Auxiliary to the Ohio State Medical Association under the leadership of Mrs. Louis Loria, President. And hard at work are the convention chairman, Mrs. Paul S. Metzger, and the convention co-chairman, Mrs. Donald L. Lewis, Franklin County, along with their advisor, Mrs. Floyd M. Beman, Franklin president. And equally hard at work, of course, are the innumerable committee members. Staging a state convention is like staging a major Broadway production. Nothing can be left to chance. From the "opening number" onstage to the finale, there must be expert direction, the ability to co-ordinate a thousand-and-one details, and the imagination and expertise to add those special "touches" that go a long way to insuring a successful production.

As you have probably gathered by now, Columbus will be setting the scene, with the spotlight on Christopher Inn. Contrary to the format of previous years, the thirty-third annual meeting will begin on a Sunday, May 6 and end on a Wednesday, May 9. A "something new" is the invitation being issued to 1973-74 county presidents and presidents-elect to attend the State Board luncheon on Monday, May 7. (For the first time last year, the new incoming Board members were invited to sit in on the preconvention Board meeting.) That will be a repeat performance this Year.

Other highlights include: Outstanding guest speakers such as Mrs. Robert F. Beckley, national auxiliary president, who will install the new officers

for 1973-74; Effie Ellis, M.D., special assistant to the Executive Vice-President of the AMA; Rev. Robert Huff, pastor of the Trinity Lutheran Church of Midland, Michigan, who will talk at the Spring Luncheon on marriage relationships.

The OMPAC luncheon on Tuesday, May 8, will feature, as speaker, Mark Russell, "the inside-Washington comedian without an equal," whose topic will be, of all things, "Politics Is A Laughing Matter!" He has been described as saying "things some of us would like to say but don't dare . . . or just aren't bright enough to say . . . ." The luncheon is scheduled for 11:30 a.m. on the 8th at the Sheraton-Columbus Hotel. The price of the tickets: \$5.00.

## Other Events

On Monday afternoon, May 7, there will be a special "Leadership Course" for 1973-74 county presidents and presidents-elect. Monday night is another "first" — a dinner for State Board members *and* their husbands (as well as for out-of-state guests) at the fascinating Japanese Steak House. Tuesday afternoon, May 8, will highlight a "Workshop Preview" for 1973-74 county presidents, presidents-elect and committee chairmen. And following the Workshop, there will be a reception, by invitation, for the county officers in the suite of the President, Mrs. Louis Loria.

Wednesday, May 9, is get-up-early time and the President's Breakfast at 7:30 a.m. The reception following the close of the business session for

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## THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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Bristolville, 44402

### *First Vice-President*

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### *Past President*

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Mrs. S. J. Glueck  
3405 Kappel Dr.  
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### *Treasurer*

Mrs. Paul Hahn  
122 Moore Ave.  
New Philadelphia, 44663



the new officers and Board members will be hosted by Columbiana County, the "home" county of the 1973-74 President, Mrs. Karl Ulicny. The "Spring Luncheon" is scheduled for 12:30 p.m. The opening business session is at 9 a.m. on Tuesday, the 8th; the second business session at 9 a.m. on Wednesday, the 9th.

The 1972-73 county presidents' report will be "staged" differently this year. The outstanding activities will be dramatized in skit form and presented at the Wednesday morning Breakfast. This year's convention theme is "Open A New Door," Mrs. Loria's focal point in her 1972-73 program.

### Facts 'n Figures

This is a run-down on the cost of the luncheons and breakfast and with whom reservations should be made:

The State Board luncheon — \$4.50; the State Board dinner at the Japanese Steak House, \$9.00; At the expense of repetition, these two functions will take place on Monday, May 7. The OMPAC luncheon at the Sheraton-Columbus, \$5.00; the Ohio State Medical Association's "Night At The Races" party \$12.50 (both OMPAC luncheon and the party are scheduled for Tuesday, May 8). Mrs. Loria's "President's Breakfast" on Wednesday morning, \$3.50; the Spring Luncheon that same day, \$4.50. Reservations for any of the foregoing should be made with Mrs. Kenneth J. Chapman, 2881 Wellesley Drive, Columbus 43221, no later than April 28. Checks should be made payable to the Auxiliary Convention Fund.

Credential cards will not be mailed to delegates and alternates. Such delegates and alternates will receive their cards when they register. This method was used successfully last year and is being repeated this year.

### Wonderful Women!

I mentioned earlier that many, many Franklin County members are working hard on this thirty-

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**(See Page 305)**

third annual convention. It isn't possible (limited space problems!) to list everyone who is doing so much. But I should like to present those chairmen whom I have not yet mentioned: Finance, Mrs. James W. Gahman; VIP guests, Mrs. Malachi W. Sloan, II; Hospitality, Mrs. James L. Best; Liaison, Mrs. Ben Arnoff; OMPAC luncheon decorations, Mrs. Fred B. Hapke; Properties, Mrs. George E. Bell; Pages, Mrs. Horace Davidson, Jr.; Printing, Mrs. Samuel Saslaw; Publicity, Mrs. Alfred Sli-vinski; Registration, Mes. Charles Rossel; Roll

Call, Mrs. Dale Dickens and Mrs. Carl Tetirick.

Sponsors, Mrs. Norris E. Lenahan and Mrs. Slivinski; Secretarial assistant, Mrs. Chester Bennett; State Board luncheon decorations, Mrs. Beman and Mrs. Donal O'Leary; Hostesses at the races, WASAMA; President's Breakfast, Mrs. Ronald Mezger; Spring Luncheon, Mrs. William Havener and Mrs. David Spangler; Hostesses (convention center and coffee lounge), Mrs. Brooks Hurd; Early Bird Prizes, Mrs. Harold W. Davis (Delaware county).

### Please Attend!

Convention time is learning time, fun time and get-together time. It is important business time too. It is your time — and opportunity — to get a remarkable bird's-eye-view of your State Auxiliary and county auxiliaries in action. Every member is most welcome. After all, you are the auxiliary's backbone!

### Mrs. F. M. Freimann

"Petey" Freimann of Cuyahoga county, deserves a headline all her own! She is our state safety chairman and she SEES things most of us would never see. And would you believe that because she saw something not even the State of Ohio's Department of Highway Safety saw, she actually, and very recently, got that state governmental department to make a correction?

I'll let the following two letters speak for themselves — and for Mrs. Freimann:

Letter Number One was sent by our alert safety gal in December to the Department of Highway Safety:

"If I may call your attention to one of the new highway signs, please note the "merge" one

(and replicas of the sign as it is, and then as it should be, were drawn on the letter). Since the straight part of the arrow designates the main thoroughfare, the merging secondary road should be marked with a narrower line. The newly appearing signs, however, use the same width; thus not stressing the "right of way" of the main highway.

"Is it just an error of the Department of Signs or is there a reason for the change from the international design? It is my observation that a large percent of drivers do not fully understand the meaning of "yield" or "merge". Maybe the narrower marking will help them realize the meaning . . . ."

Letter Number Two from the Department of Highways early in January! "Your recent letter to Director O'Grady concerning the design of merging traffic signs has been forwarded to this office for reply. You are quite correct in your observation that some of the merge signs now being displayed in Ohio show the through roadway and the merging roadway with the same width line on the symbol. Your observation that this display is not exactly in conformance with the Federal Standard is also correct.

"Some of our Traffic Engineers feel that the sign, as now designed, has better target value and can be recognized from a greater distance. They also point out that there are places where merging traffic signs are displayed when neither roadway actually has the right of way. These instances, however, occur very infrequently as compared to the usual instances where this sign is displayed at locations where ramp traffic enters the main line on expressways and freeways.

*"I have requested our Bureau of Traffic Control to issue a new standard drawing for this sign*

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*in accordance with the National Standard, and to utilize only the new design henceforth.*

"Thank you very much for taking the time to write and bring this matter to our attention...." Signed by J. Phillip Richley, Director of Transportation.

What was that old, old expression "you can't fight City Hall"??? Guess our Petey Freimann never even heard of it! Thanks, and an orchid, to an outstanding auxiliary member.

### Happy Birthday

Mobile Meals of Toledo, the founding of which was instigated by the Lucas County auxiliary, celebrated its fifth anniversary in December with an "Open House" at the Toledo Academy of Medicine. Volunteers, health department and city officials and medical social workers were on the guest list, and greeted by Mrs. Daniel S. Wolff, Mobile Meals president. (Mrs. Wolff serves as membership chairman on our State Board). Also present was the charter president of the group, Mrs. Howard E. Smith, state auxiliary second vice-president. Another of the day's hostesses was Mrs. Burton Nelson, Lucas auxiliary president, whose group continues to heavily support and participate in the Mobile Meals program.

Mrs. Wolff advises me that for the five-year period, the program has served 759 different subscribers, with a daily average of approximately 125 men and women. During 1972, a total of 82,728 meals were delivered. Volunteers gave about 15,000 hours in addition to donating the use of their cars and gasoline. Food is prepared in the kitchens of six Toledo hospitals including St. Luke's where the pilot project was born. The other hospitals are St. Charles, Mercy, St. Vincent's, Parkview, and Toledo. The seventh food base is the Lutheran Old Folks Home.

Comments Mrs. Wolff: "Like mailmen who let neither snow, rain, heat nor gloom of night stay them from their appointed rounds, Mobile Meals workers have never missed a day on the job." Those volunteers are 600 strong. Congratulations to a terrific group of dedicated women....

### Around the State

The second in the series on Child Abuse sponsored by the Cuyahoga County auxiliary was held in January at a luncheon meeting at the Sheraton-Cleveland Hotel. Four experts from county agencies dealing with the problem were the guest speakers — Mrs. Sadye Monroe, child abuse registrar with the welfare department; Dr. John Kennell, a pediatrician and associate professor at Case-Western Reserve University; Dr. Lester Adelson, deputy county coroner; and Lt. Violet Novak, Cleveland police officer.

Dr. Kennell presented an overview of child abuse while the other three speakers explained how their agencies approach the problem. Here are a few interesting quotes from the speakers:

"Ninety percent of abusers can be rehabilitated if given the proper aid. But we have to get off this 'did it occur' and 'who done it' kick and get on to helping this child and his troubled family." (Dr. Kennell)

"Abusing the child may be the only way the parent knows to bring a crisis to the attention of the community. Rarely is abusing a child a deliberate act of cruelty. Rather it expresses the parent's inability to cope with pressures." (Mrs. Monroe)

"When a report of child abuse is received, a team of plain-clothes policewomen is sent to the home to investigate. The investigation may or may not lead to criminal charges, but any attempts at social service are left to county welfare officials



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President

and are not assumed by the police themselves.” (Lt. Novak)

“When a child comes to the attention of the coroner’s office, it’s too late. We have the least pleasant relationship to the child abuse problem. Yet the coroner’s office has the responsibility of determining when a child’s death has resulted from parental abuse. We immediately call the police when we determine a child was fatally abused. Many people physically capable of reproducing are not emotionally or intellectually able to raise children. People must realize the act of creation of another life is a very, very serious responsibility.” (Dr. Adelson)

### A “Valentine”

The Erie County auxiliary held a Valentine Dinner in February in Sandusky after which a review of proposed medical legislation was presented. Panelists were Dr. and Mrs. S. Baird Pfahl and Dr. and Mrs. Charles Everett. They explained major points of all bills introduced in Congress, noting the current status of each, as well as the status of the Professional Standards Review Organization and the Health Maintenance Organizations. “The Case For American Medicine” by Harry Schwartz was also reviewed.

The Erie County Medical Society has made plans to place this book in school and public libraries in the county. The auxiliary has made plans to send the book to state and national legislators. Members of the press, radio and television who were the group’s dinner guests expressed appreciation for a valuable briefing session. Also present were Mrs. Louis Loria, state auxiliary president, and the Honorable Jackson E. Betts, former Congressman. Mrs. Loria met the following morning for a “work session” with the officers and committee chairmen of the auxiliary.

### A Nice Thought

From Mr. Shakespeare: “When proud-pied April, dress’d in all his trim, Hath put a spirit of youth in everything” . . .



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## Columbus Physician Named Chairman of OMPAC Board Of Directors

H. William Porterfield, M.D., Columbus, has been elected Chairman of the Ohio Medical Political Action Committee Board of Directors. Dr. Porterfield has been serving as Vice-Chairman of the OMPAC Board and succeeds William J. Lewis, M.D., Dayton. Dr. Lewis was recently elected Chairman of the American Political Action Committee Board of Directors.

Ray W. Gifford, Jr., M.D., Cleveland, has been elected to succeed Dr. Porterfield as Vice-Chairman of the OMPAC Board and Paul A. Jones, M.D., Zanesville, remains as the Secretary-Treasurer.

Among other activities during the February 28 Board meeting, the Board agreed to emphasize that each county medical society and/or hospital staff should be encouraged to develop a "key-man" for OMPAC to act as the educational liaison between the Board and the OMPAC membership. The Board is going to have a concerted effort toward increasing OMPAC membership both in 1973 and in 1974 as the need for candidate support increases toward the 1974 election.

If you are currently a member of OMPAC, you should encourage your fellow physicians and their wives to join also so that your membership becomes more valuable. If you are not currently an OMPAC member, please consider becoming one. OMPAC is the strong right arm of organized medicine within the State of Ohio. Membership dues should be forwarded to your county medical society secretary or may be sent directly to the OMPAC office, Box 5617, Columbus, Ohio 43221.

\* \* \* \* \*

"The future is now," is the headline attached to the following comment in *Politics*, publication of BIPAC, the political newsletter of the business-industry PAC:

"One of the enduring cliches of the boxing ring, which applies equally to the field of politics, is that you can't beat somebody with nobody. . . .

"Candidates for political office who show promise have to be spotted early and given encouragement, incentive, the desire to win and the necessary financial backing if positions of political responsibility are to be captured. . . .

"Two years is not a very long time in politics to get ready for the next election. Political interests who believe the nation's future lies in the free

market system, sound financial practices and a pragmatic approach to solving problems should now be laying plans to keep seats in the United States Congress out of the hand of ultra-liberals in 1974 and beyond. . . .

"In politics, as in the prize ring, the development of 'somebodies' is a long term proposition which must be started well in advance of the need to put electable candidates on the slate."

**BE SURE TO MAKE YOUR 1973 CONTRIBUTION TO OMPAC.**

—Ohio Medical Political Action Committee

### PUBLIC PRESS QUOTE

## AMA off Drugs

The American Medical Association (AMA) apparently tired of its forthright stand on problems of drug pricing and prescribing and decided to engage in a forthright collapse.

Three members of the AMA's council on drugs recently said their council was dissolved because it was irritating the pharmaceutical lobby too much. The council had been publishing a little booklet that suggested some drug combinations were "irrational." One council member said he was told that the pharmaceutical folks were a friend to the physicians, and that drug ads were important to the AMA Journal.

The association, in turn, has said that four councils and six committees were abolished. The association said the need for the drug council no longer exists because the Food and Drug administration (FDA) is doing all the regulating.

Well, the FDA is trying, but it can't do the job alone. A lot of doctors regard the FDA as a remote agency that doesn't get involved in the workaday problems. So it helps if the doctors have their own source of criticism and guidance in prescribing drugs.

But, like some of the new hypodermic needles that some doctors use, disposables are more convenient. Disposable responsibilities, for example.

—Dayton Daily News





# MEMBERS OF THE 1973 HOUSE OF DELEGATES

Listed in the following columns are Delegates and Alternate Delegates to the Ohio State Medical Association House of Delegates, as reported from each county to represent their respective County Medical Societies at the 1973 OSMA Annual Meeting, May 6-9. All business sessions of the House of Delegates will be held at the Sheraton-Columbus Hotel.

## COUNTIES

### Delegates

### Alternates

#### FIRST DISTRICT

#### ADAMS

Francis L. Stevens

William J. Lundy

#### BROWN

John R. Donohoo

Charles H. Maly

#### BUTLER

James M. Smith  
Jerry D. Hammond  
James F. Stewart

John C. Gillen  
Frank C. Palmer  
James I. Scott, Jr.

#### CLERMONT

Carl A. Minning

Donald R. Morath

#### CLINTON

Foster J. Boyd

#### HAMILTON

Ambrose H. Clement  
Frank P. Cleveland  
Joseph G. Crotty  
Wm. R. Culbertson, Jr.  
Charles D. Feuss, Jr.  
Milton W. Gwinner  
Robert S. Heidt  
Harry K. Hines  
Stephen P. Hogg  
Marvin McClellan  
Glenn W. Pfister  
Clyde S. Roof  
Harold Schiro  
Albert E. Thielen  
Andrew J. Weiss

John E. Albers  
Donald E. Brinkman  
Frederick Brockmeier  
Eugene J. Burns  
George D.J. Griffin  
James L. Leonard  
Frederick T. Martin  
H. Glenn Overley  
Joseph O. Porter  
Eli Rubenstein  
Elmer Schlueter  
Carl J. Schmidt  
William J. Schrimpf  
Calvin F. Warner

#### HIGHLAND

#### WARREN

Thomas E. Fox

Gary P. Hayes

#### SECOND DISTRICT

#### CHAMPAIGN

Isador Miller

M. J. Towle

#### CLARK

Ernest H. Winterhoff  
Henry A. Diederichs

James W. Keller  
Dale E. French

#### DARKE

Jesse L. Heise

Jose R. Solis

#### GREENE

Roger C. Henderson

Paul C. Vernier

#### MIAMI

Jerry L. Hammon

A. Robert Davies

## COUNTIES

### Delegates

### Alternates

#### MONTGOMERY

Don E. Sando  
William J. Lewis  
Benjamin Schuster  
A. J. Gabriele  
John H. Taylor

Robert L. Hoffman  
Samuel A. Laneve  
Konrad A. Kircher  
John R. Whitaker, Jr.  
Frederic C. Schnebly

#### PREBLE

Chester J. Brian

E. P. Trittschuh

#### SHELBY

George J. Schroer

#### THIRD DISTRICT

#### ALLEN

David A. Barr  
J. M. Oppenheim

Alexander C. Reed  
Robert L. Holladay

#### AUGLAIZE

Robert Oyer

Elizabeth Kuffner

#### CRAWFORD

H. B. Newhard

D. D. Bibler

#### HANCOCK

Chester L. Samuelson

Carson P. Cochran

#### HARDIN

Robert B. Elliott

John Hughes

#### LOGAN

James H. Steiner

Charles L. Barrett

#### MARION

Paul E. Lyon

Thomas N. Quilter

#### MERCER

James J. Otis

George H. McIlroy

#### SENECA

Walter A. Daniel

John Bauer

#### VAN WERT

A. C. Diller

Wilmer L. Iler

#### WYANDOT

Joseph J. Browne

Herschel A. Rhodes

#### FOURTH DISTRICT

#### DEFIANCE

Paul E. Brose

Nicolas E. Balmoria

#### FULTON

Benjamin H. Reed, Jr.

William J. Neal

COUNTIES

| Delegates               | Alternates         |
|-------------------------|--------------------|
| HENRY                   |                    |
| T. F. Moriarty          | R. C. Soriano      |
| LUCAS                   |                    |
| Frederick P. Osgood     | Theron L. Hopple   |
| Charles D. Ford         | M. Brodie James    |
| Bernard L. Huffman, Jr. | Thomas J. O'Grady  |
| Roland A. Gandy, Jr.    | Richard J. Wiseley |
| Harry C. Mack           | Robert Page        |
| Peter A. Overstreet     | Harry L. Snyder    |
| OTTAWA                  |                    |
| John F. Bodie           | Patrick Hughes     |
| PAULDING                |                    |
| Doyt E. Farling         | Don K. Snyder      |
| PUTNAM                  |                    |
| James B. Overmier       | John R. Brown      |
| SANDUSKY                |                    |
| Willis L. Damschroder   |                    |
| WILLIAMS                |                    |
| Robert W. Dilworth      | John E. Moats      |
| WOOD                    |                    |
| William H. Roberts      | Clarence B. Nyce   |

FIFTH DISTRICT

|                       |                            |
|-----------------------|----------------------------|
| ASHTABULA             |                            |
| Shepard A. Burroughs  | James G. Macaulay          |
| CUYAHOGA              |                            |
| James O. Barr         | John E. Coletta            |
| Matthew R. Biscotti   | Christopher A. Colombi     |
| William F. Boukalik   | Peter Coppedge             |
| John H. Budd          | Caldwell B. Esselstyn, Jr. |
| Theodore J. Castele   | James P. Farmer            |
| Henry A. Crawford     | Eugene A. Ferreri          |
| Nicholas G. DePiero   | James E. Fleming           |
| John J. Gaughn        | Charles A. Hubay           |
| Clarence L. Huggins   | James C. Jones             |
| Roscoe J. Kennedy     | Edward F. Kieger           |
| John A. Kmieck        | Steven Kovacs              |
| Vincent T. LaMaida    | Fred V. Light              |
| George P. Leicht      | William A. Mast            |
| Leonard L. Lovshin    | Pierce H. Mullally         |
| Hermann Menges, Jr.   | Thomas H. Redding          |
| James R. O'Malley     | Robert P. Riley            |
| George W. Petznick    | Flory M. Sandoval          |
| John H. Sanders       | Howard S. Siegel           |
| A. B. Schneider, Jr.  | Warner W. Tuckerman        |
| Frederick T. Suppes   | Robert C. Waltz            |
| William V. Trowbridge | Robert W. Wido             |
| Howard Van Ordstrand  | Ralph G. Wieland, Jr.      |
| Julius Volkin         |                            |
| GEAUGA                |                            |
| Alton W. Behm         | Arturo J. Dimaculangan     |
| LAKE                  |                            |
| Carl G. Madsen, Jr.   | Edward D. Hudgens          |
| Wesley J. Pignolet    | Harry A. Killian           |

SIXTH DISTRICT

|                     |                      |
|---------------------|----------------------|
| COLUMBIANA          |                      |
| William S. Banfield | Leonard S. Pritchard |
| MAHONING            |                      |
| C. E. Pichette      | J. James Anderson    |
| Jack Schreiber      | C. Conner White, Jr. |
| John C. Melnick     | Rashid A. Abdu       |
| Felix A. Pesa       | Loren J. Zehr        |
| PORTAGE             |                      |
|                     | George R. Sprogis    |

COUNTIES

| Delegates             | Alternates          |
|-----------------------|---------------------|
| STARK                 |                     |
| William A. White, Jr. | James C. Hays       |
| Edward E. Grable      | Walter J. Telesz    |
| Frank O. Goodnough    | Daniel A. Kibler    |
| E. Joel Davis         | Joseph P. Yut       |
| SUMMIT                |                     |
| William Dorner        | Robert R. Clark     |
| Emmett P. Monroe      | Joseph L. Kloss     |
| Lynn F. DeFreest      | W. Paul Kilway, Jr. |
| Rocco M. Antenucci    | John D. Morley      |
| John C. Johns         |                     |
| J. A. Karnoupakis     |                     |
| TRUMBULL              |                     |
| Robert J. Paul        | George Mokris       |
| Joseph L. Logan       | Jerome J. Stanislaw |

SEVENTH DISTRICT

|                    |                    |
|--------------------|--------------------|
| BELMONT            |                    |
| Luis Vanquez       | A. John Antalis    |
| CARROLL            |                    |
| Carl A. Lincke     | Samuel L. Weir     |
| COSHOCTON          |                    |
| Norman L. Wright   | Donald E. Potts    |
| HARRISON           |                    |
| Elias Freeman      | Janis Trupovnieks  |
| JEFFERSON          |                    |
| Sanford Press      | Francis A. Sunseri |
| MONROE             |                    |
| Byron Gillespie    |                    |
| TUSCARAWAS         |                    |
| Philip T. Doughten | Harvey J. Reamy    |

EIGHTH DISTRICT

|                     |                     |
|---------------------|---------------------|
| ATHENS              |                     |
| Leland P. Randles   | John F. Kroner, Jr. |
| FAIRFIELD           |                     |
| Richard E. Hartle   | Donald B. Nichols   |
| GUERNSEY            |                     |
| Robert A. Ringer    |                     |
| LICKING             |                     |
| Irving A. Nickerson | Carl M. Frye        |
| MORGAN              |                     |
| Austin A. Coulson   | Henry Bachman       |
| MUSKINGUM           |                     |
| Walter B. Devine    | Carl E. Spragg      |

|                       |                       |
|-----------------------|-----------------------|
| NOBLE                 |                       |
| Edward G. Ditch       | Frederick M. Cox      |
| PERRY                 |                       |
| George C. Tedrow      | Arthur L. Dobosiewicz |
| WASHINGTON            |                       |
| Gregory B. Krivchenia | Mary L. Whitacre      |

NINTH DISTRICT

|                      |                   |
|----------------------|-------------------|
| GALLIA               |                   |
| Thomas P. Price, Jr. | Edward J. Berkich |
| HOCKING              |                   |
| Jan S. Matthews      | L. W. Starr       |

| COUNTIES       | Delegates   | Alternates   |
|----------------|---|--|
| JACKSON        | John W. Zimmerly  | Carl J. Greever  |
| LAWRENCE       | Harry Nenni   | A. Burton Payne  |
| MEIGS          | Roger Daniels   |  |
| PIKE           | Robert T. Leever  | Albert M. Shrader  |
| SCIOTO         | Chester H. Allen  | Carter L. Pitcher  |
| VINTON         |   |  |
| TENTH DISTRICT |   |  |
| DELAWARE       | Robert S. Caulkins, Jr.   | Adelbert R. Callander  |
| FAYETTE        | Ralph Gebhart   | Thomas J. Hancock  |
| FRANKLIN       | Homer A. Anderson<br>Michael A. Anthony<br>Robert C. Atkinson<br>James E. Barnes<br>Joseph A. Bonta<br>Richard L. Fulton<br>Keith DeVoe, Jr.<br>John N. Meagher<br>H. William Porterfield | Drew J. Arnold<br>James C. Good<br>Walter M. Haynes, Jr.<br>Thomas M. Hughes<br>Ben E. Jacoby<br>Charles W. Pavey<br>Philip H. Taylor<br>Donald W. Traphagen<br>James Hutchison Williams |
| KNOX           | Henry T. Lapp   | Charles E. Cassaday  |
| MADISON        | Sol Maggied   | William T. Bacon   |
| MORROW         | Joseph P. Ingmire   | David James Hickson  |
| PICKAWAY       | Jasper M. Hedges  | Emily E. Lutz  |
| ROSS           | Joseph S. McKell  | Richard L. Counts  |

| COUNTIES          | Delegates   | Alternates   |
|-------------------|---|--|
| UNION             | Paul R. Zaugg   | Walter R. Burt   |
| ELEVENTH DISTRICT |   |  |
| ASHLAND           | Jon Cooperrider   | Charles Warne  |
| ERIE              | S. Baird Pfahl, Jr.   | Emil J. Meckstroth   |
| HOLMES            | Luther W. High  | Maurice E. Mullet  |
| HURON             | Nino M. Camardese   | Earl R. McLoney  |
| LORAIN            | Charles G. Adams<br>James T. Stephens<br>Henry E. Kleinhenz | William H. Miller<br>John N. Bartone<br>Harold E. McDonald |
| MEDINA            | Richard W. Avery  | Rolland L. Mansell   |
| RICHLAND          | Hall S. Wiedemer<br>Harold F. Mills                         | Wendell M. Bell<br>Charles B. Phillips                     |
| WAYNE             | Albert B. Huff  | John M. Robinson   |

OFFICERS

|                           |                    |
|---------------------------|--------------------|
| President .....           | William R. Schultz |
| President-Elect .....     | Oscar W. Clarke    |
| Past President .....      | P. John Robeckek   |
| Secretary-Treasurer ..... | James L. Henry     |

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|-------------------------|------------------------|
| First District .....    | Stephen P. Hogg        |
| Second District .....   | James G. Tye           |
| Third District .....    | John C. Smithson       |
| Fourth District .....   | George N. Bates        |
| Fifth District .....    | David Fishman          |
| Sixth District .....    | Maurice F. Lieber      |
| Seventh District .....  | Robert E. Rinderknecht |
| Eighth District .....   | William M. Wells       |
| Ninth District .....    | Thomas W. Morgan       |
| Tenth District .....    | James C. McLarnan      |
| Eleventh District ..... | Robert G. Thomas       |





# HOUSE OF DELEGATES

**SUNDAY, MAY 6, 1973**

3:00-7:00 P.M.

Registration for OSMA House of Delegates  
Terrestrial Promenade  
Second Floor  
Sheraton-Columbus Hotel

4:00 P.M.

Councilor District Caucus Meetings  
Sheraton-Columbus Hotel

| District | Councilor              | Studio Room                |
|----------|------------------------|----------------------------|
| First    | Stephen P. Hogg        | 1601                       |
| Second   | James G. Tye           | 1614                       |
| Third    | John C. Smithson       | 1622                       |
| Fourth   | George N. Bates        | 1701                       |
| Fifth    | David Fishman          | Taft Room<br>(Third Floor) |
| Sixth    | Maurice F. Lieber      | 1722                       |
| Seventh  | Robert E. Rinderknecht | 1801                       |
| Eighth   | William M. Wells       | 1814                       |
| Ninth    | Thomas W. Morgan       | 1822                       |
| Tenth    | James C. McLarnan      | 1901                       |
| Eleventh | Robert G. Thomas       | 1914                       |

5:30 P.M.

Buffet Dinner for Delegates, Alternates  
OSMA Council and Official Guests  
Mars and Venus Rooms, Second Floor  
Sheraton-Columbus Hotel

7:00 P.M.

First Business Session, House of Delegates  
Jupiter and Saturn Rooms, Second Floor  
Sheraton-Columbus Hotel

## BUSINESS AGENDA

First Session, House of Delegates  
7:00 P.M.

Call to order by the President—William R. Schultz, M.D., Wooster.

Invocation—Charles A. Sebastian, M.D., Cincinnati.

Welcome by Ben Arnoff, M.D., Columbus, President, Academy of Medicine of Columbus and Franklin County.

**SUNDAY (Contd.)**

Address: Raymond T. Holden, M.D., AMA, Trustee, Washington, D.C.

Report of the Committee on Credentials.

Consideration of the Minutes of the last Annual Meeting (July 1972 issue of *The Journal*.)

Introduction of honored guests.

Report of the President of the Woman's Auxiliary  
—Mrs. L. A. Loria, Bristolville.

Presentation of AMA-ERF checks to representatives of Ohio medical schools—Philip B. Hardyman, M.D., Chairman, Ohio Committee on AMA-ERF

University of Cincinnati College of Medicine

Case Western Reserve University School of Medicine

Ohio State University College of Medicine

Medical College of Ohio at Toledo

Presentation of plaques to Past Councilors and retiring AMA Delegates and Alternates; Chairmen and members of Standing Committees and Chairmen of Special Committees.

Presentation of Distinguished Service Citation.

Announcement of appointments to the Reference Committees by the President: Credentials; President's Address; Resolutions; and Tellers and Judges of Election.

Election of Committee on Nominations:

(Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final Session, Wednesday, May 9, 3:30 p.m., its recommendations in the form of a ticket containing nominees for officers to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Eleventh District shall serve as chairman). The report of the Nominating Committee with respect to all offices except President-elect shall be posted at registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

## SUNDAY (Contd.)

### President's Address:

William R. Schultz, M.D., Wooster.

### Introduction of Presidentss of other State Societies.

### Introduction of Resolutions:

(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Wednesday afternoon session before any action can be taken. All resolutions not submitted in advance of the 60-day deadline must be typewritten and submitted in triplicate.)

### Miscellaneous Business.

MONDAY, MAY 7, 1973

## MEETING OF REFERENCE COMMITTEES

(All Reference Committee Meetings held in Sheraton-Columbus Hotel)

8:30 A.M.

### Resolutions Committee No. 1—

Auditorium, Third Floor

### Resolutions Committee No. 2—

McKinley-Harding Rooms, Third Floor

### Resolutions Committee No. 3—

Harrison Rooms, Third Floor

### Resolutions Committee No. 4—

Taft Room, Third Floor

### President's Address—

Garfield-Hayes Rooms, Third Floor

### Committee on Nominations—

Grant Room, Third Floor

(Note: If necessary, the Reference Committees will meet in the same rooms, Monday afternoon, May 7, 1:30 P.M.)

## REFERENCE COMMITTEE APPOINTMENTS

### PRESIDENT'S ADDRESS

*Chairman:* Luther W. High, M.D.

(Holmes County)

Richard L. Fulton, M.D.

(Franklin County)

Harold Schiro, M.D.

(Hamilton County)

John J. Gaughan, M.D.

(Cuyahoga County)

### TELLERS AND JUDGES OF ELECTION

*Chairman:* Earl R. McLoney, M.D.

(Huron County)

## MONDAY (Contd.)

Robert C. Waltz, M.D.

(Cuyahoga County)

John E. Albers, M.D.

(Hamilton County)

A. Burton Payne, M.D.

(Lawrence County)

Philip H. Taylor, M.D.

(Franklin County)

Harry A. Killian, M.D.

(Lake County)

### CREDENTIALS OF DELEGATES

*Chairman:* Robert B. Elliott, M.D.

(Hardin County)

Marvin McClellan, M.D.

(Hamilton County)

Irving A. Nickerson, M.D.

(Licking County)

Richard W. Avery, M.D.

(Medina County)

### RESOLUTIONS COMMITTEE NO. 1

*Chairman:* John N. Meagher, M.D.

(Franklin County)

William V. Trowbridge, M.D.

(Cuyahoga County)

William J. Lewis, Jr., M.D.

(Montgomery County)

Thomas E. Fox, M.D.

(Warren County)

Chester L. Samuelson, M.D.

(Hancock County)

Harry C. Mack, M.D.

(Lucas County)

Sanford Press, M.D.

(Jefferson County)

Walter B. Devine, M.D.

(Muskingum County)

Thomas P. Price, Jr., M.D.

(Gallia County)

William Dörner, M.D.

(Summit County)

James T. Stephens, M.D.

(Lorain County)

### RESOLUTIONS COMMITTEE NO. 2

*Chairman:* Jasper M. Hedges, M.D.

(Pickaway County)

Peter A. Overstreet, M.D.

(Lucas County)

Frank P. Cleveland, M.D.

(Hamilton County)

Jerry L. Hammon, M.D.

(Miami County)

Paul E. Lyon, M.D.

(Marion County)

Jack Schreiber, M.D.

(Mahoning County)

## MONDAY (Contd.)

Philip T. Doughen, M.D.  
(Tuscarawas County)  
Leland P. Randles, M.D.  
(Athens County)  
John W. Zimmerly, M.D.  
(Jackson County)  
Henry A. Crawford, M.D.  
(Cuyahoga County)  
S. Baird Pfahl, Jr., M.D.  
(Erie County)

### RESOLUTIONS COMMITTEE NO. 3

*Chairman:* Clarence L. Huggins, M.D.  
(Cuyahoga County)  
William R. Culbertson, Jr., M.D.  
(Hamilton County)  
George J. Schroer, M.D.  
(Shelby County)  
David A. Barr, M.D.  
(Allen County)  
T. F. Moriarty, M.D.  
(Henry County)  
Keith DeVoe, Jr., M.D.  
(Franklin County)  
Edward E. Grable, M.D.  
(Stark County)  
Carl A. Lincke, M.D.  
(Carroll County)  
Robert A. Ringer, M.D.  
(Guernsey County)

## MONDAY (Contd.)

Harry Nenni, M.D.  
(Lawrence County)  
Hall S. Wiedemer, M.D.  
(Richland County)

### RESOLUTIONS COMMITTEE NO. 4

*Chairman:* Frederick P. Osgood, M.D.  
(Lucas County)  
Andrew J. Weiss, M.D.  
(Hamilton County)  
Ernest H. Winterhoff, M.D.  
(Clark County)  
James H. Steiner, M.D.  
(Logan County)  
Carl G. Madsen, Jr., M.D.  
(Lake County)  
E. Joel Davis, M.D.  
(Stark County)  
Norman L. Wright, M.D.  
(Coshocton County)  
Richard E. Hartle, M.D.  
(Fairfield County)  
Chester H. Allen, M.D.  
(Scioto County)  
Joseph A. Bonta, M.D.  
(Franklin County)  
Charles G. Adams, M.D.  
(Lorain County)

# HOUSE OF DELEGATES

## FINAL SESSION

WEDNESDAY, MAY 9, 1973

2:30 - 3:30 P.M.

Registration for OSMA House of Delegates  
Terrestrial Promenade, Second Floor  
Sheraton-Columbus Hotel

3:30 P.M.

OSMA House of Delegates Final Business Session  
Jupiter and Saturn Rooms, Second Floor  
Sheraton-Columbus Hotel

5:30 P.M.

Buffet Dinner for Delegates, Alternates, OSMA  
Council and Official Guests  
Mars and Venus Rooms, Second Floor  
Sheraton-Columbus Hotel

## BUSINESS AGENDA

Final Session, House of Delegates

Introduction of Guests

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and election  
of other officers.

(a) Nominations for The Council.

(Members of The Council are elected for  
two-year terms; terms of those represent-  
ing the even-numbered districts expire in  
odd-numbered years).

Second District — (Incumbent, James  
G. Tye, M.D., Dayton)



Fourth District — (Incumbent, George N. Bates, M.D., Toledo)  
 Sixth District — (Incumbent, Maurice F. Lieber, M.D., Canton)  
 Eighth District—(Incumbent, William M. Wells, M.D., Newark)  
 Tenth District — (Incumbent, James C. McLarnan, M.D., Mt. Vernon)  
 Secretary - Treasurer — (Incumbent, James L. Henry, M.D., Grove City)  
 (Note: Ineligible for re-election having served the maximum time as Secretary-Treasurer as provided in the Constitution and Bylaws of the Association)

Alternates: (Listed Alphabetically)  
 George N. Bates, M.D., Toledo  
 Richard L. Fulton, M.D., Columbus  
 Jerry L. Hammon, M.D., West Milton  
 William J. Lewis, Jr., M.D., Dayton  
 Jack Schreiber, M.D., Canfield  
 (one vacancy) created when Robert P. Johnson, M.D., Middletown resigned.  
 Dr. Johnson was elected Alternate beginning January 1, 1973 and ending December 31, 1974.

- (b) Election of Delegates and Alternates to the American Medical Association — 5 Delegates and 5 Alternates to be elected each for a two-year term starting January 1, 1974 in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1973, their terms expiring December 31, 1973.

Delegates: (Listed Alphabetically)  
 Oscar W. Clarke, M.D., Gallipolis  
 Henry A. Crawford, M.D., Cleveland  
 Harry K. Hines, M.D., Cincinnati  
 Frederick P. Osgood, M.D., Toledo  
 P. John Robeck, M.D., Cleveland

All nominees for the office of AMA Delegates and AMA Alternate shall run at large.

Election of Delegates and Alternates of the AMA shall be governed by Section 6, Chapter 5 of the OSMA Constitution and Bylaws as revised by the House of Delegates in May, 1971.

Reports of Reference Committees.

President's Address  
 Resolutions Committee No. 1  
 Resolutions Committee No. 2  
 Resolutions Committee No. 3  
 Resolutions Committee No. 4

Miscellaneous Business

Installation of Officers for 1973-74.

Announcement of Standing Committee Appointments by the newly installed President and action thereon by House of Delegates.

Unfinished business.

Adjournment.

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## JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products and let them know that you see their advertising in *The Journal*.

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Rates: 50 cents per line. Minimum charge \$1.00 for each insertion. Display classified, \$1.00 per line. (9 lines to the inch) Prices cover the cost of remailing answers. Forms close the 8th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

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17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

**OHIO, FAIRFIELD:** Space available in modern Medical Building, 15 miles from Cincinnati. General Practitioner and Specialist needed. Reply to Box 616, c/o The Ohio State Medical Journal.

**GROUP FAMILY PRACTICE**—Excellent opportunity for family practice in pleasant, progressive town near Columbus, Ohio. No OB; well-equipped medical center, 5200 sq. ft., including twelve examining rooms, small surgery, own laboratory and x-ray; three GP's already in practice; part-time coverage of college health service; modern well-equipped 350-bed community hospital with active consulting service and ER group 4 miles from office; excellent local schools. Salary plus percentage first year. Write to Granville Medical Center, Inc., Granville, Ohio 43023.

**PHYSICIAN'S OFFICE FOR RENT** in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio, Phone 271-0291.

**WANTED: FAMILY PHYSICIANS, ORTHOPEDISTS, ENT, OB-GYN, PEDIATRICIAN, CARDIOLOGIST. ALL SURGICAL SPECIALTIES.** All new medical center adjacent to new 206-bed hospital. All specialties plus strong family practice nucleus. Many shared services. Computer. Lease. Potential buy-in. Start up financing available. Reply Box 669, c/o Ohio State Medical Journal.

**FOR RENT:** Large family cottage with tennis court on lake, Northern Michigan. Available May through October by the week. Reply Box 675, c/o Ohio State Medical Journal.

## GENERAL PRACTITIONER RETIRING

Equipment, 5 rooms and patient records. Availability and terms can be arranged to mutual satisfaction. Located in the middle of downtown, five minutes walk to hospital, which is accredited and has all medical services represented; staff no problem. Ample parking. Must see to appreciate. South East Ohio. University Town. Reply Box 660 c/o Ohio State Medical Journal.

**DIRECTOR OF FAMILY PRACTICE PROGRAM:** The search committee of the Family Practice Residency Committee of the Toledo Hospital, Toledo, Ohio 43606, is prepared to interview interested physicians for a full-time position in a new Family Practice Residency Program to begin about September 1, 1973. For information or an appointment for interview please contact: Henry R. Silverman, M.D. 4352 Sylvania Avenue, Toledo, Ohio 43623. Telephone: 419/882-7165.

**IMMEDIATE OPENING** for Ob-Gyn, Internal Medicine and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

**OHIO, AKRON:** Exciting opportunity for psychiatrist interested in taking over an out-patient private practice. Net income \$40,000 and up. Consultation to local agencies, hospital privileges, teaching also available. Contact Box 670 c/o Ohio State Medical Journal.

**VACATION CONDOMINIUM** — New Smyrna Beach, Fla. — just south of Daytona and away from the crowds, but enjoying the same beautiful beach. Two bedrooms, 2 baths, wall-to-wall carpeting, completely and tastefully furnished including linens, color TV and dishwasher, **HEATED POOL**, and sauna. \$400 per month. For reservations or further information, contact Wm. W. Conner, M.D., 517 Lakeshore Dr., Eustis, Florida 32726. Phone 904-357-5715.

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— More Classified Ads on Next Page —



## CLASSIFIED ADVERTISEMENTS

(Continued from Previous Page)

**WANTED: LOCUM TENENS** for E.R. for 1-2-3 months in July, August or September. \$3,000 plus my own house per month. Opportunity to join group as fifth man is open! Contact: B. Sarihan, M.D., 2501 Marinette Dr., Springfield, Ohio. 45503, Tel: 513-399-7828.

**FAMILY PRACTICE RESIDENCY** — Just approved — openings at all levels — can start immediately — for details contact: A. J. Pultz, M.D., Chairman. Family Practice Committee, Grant Hospital, 309 E. State, Columbus, Ohio 43215.

**OB-GYN—BOARD ELIGIBLE OR CERTIFIED** to join certified Obstetrician-Gynecologist in suburb of medium sized city in southwestern Ohio. Excellent salary first year; partnership second year. Ample time off. Good schools. Leisurely life. Send curriculum vitae to Box 668, c/o Ohio State Medical Journal.

**UNIVERSITY HEALTH SERVICE—Ohio**—Excellent opportunity to join compatible staff in well equipped modern facility; liberal vacation and time off with many other fringe benefits; salary negotiable. Contact: Henry Vogtsberger, M.D., Student Medical Center, Bowling Green State University, Bowling Green, Ohio 43043. An Equal Opportunity Employer.

**IMMEDIATE OPENING** for general practitioner to associate in Family Practice Medicine in well established modern office in suburb of industrial northeastern Ohio city. OB optional. Hours excellent. Reply Box 676, c/o Ohio State Medical Journal.

**HOUSE PHYSICIANS MEDICAL AND SURGICAL ECFMG CERTIFICATE REQUIRED.** Board eligibility desirable. Salary commensurate with training and experience. Fringe benefits include paid hospitalization, uniforms, meals, and malpractice insurance. Contact: Dept. of Medical Education, Lakewood Hospital, 14519 Detroit Road, Lakewood, Ohio 44107.

**HOUSE PHYSICIANS — POSITIONS AVAILABLE IMMEDIATELY:** Medicine, Surgery, Pediatrics and OB-Gyn. 500 bed general hospital. Housing available, excellent fringe benefits. Salary negotiable. Preference given Board eligible physicians. Immigration visa required for FMGs. Include training resume. Contact Adolfo D. Games, M.D., F.A.C.G., Director of Medical Education, Trumbull Memorial Hospital, 1350 E. Market St., Warren, Ohio 44482.

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**WANTED:** Board certified or eligible Ob-Gyn with military obligation completed to associate with certified Ob-Gyn in central Ohio. Salary with bonus first year—full partnership after two years. Modern hospital. Contact: Benjamin Zolo, M.D., 1320 Granville Rd., Newark, Ohio 43055. Phone 614/344-1196.

**PSYCHIATRISTS**—The Northville Program now has openings for Staff Psychiatrists in its Adult, Young Adult, Community Mental Health Center and Crisis Center operations in the Detroit Metropolitan Area. Our unitized clinical and administrative structure involves 14 units of 33 beds. Each unit conducts its own admission, inpatient and outpatient program. These positions require completion of an approved residency program and possession of (or eligibility for) a Michigan medical license. The salaries go as high as \$32,280 depending on qualifications. A sound fringe benefit program is provided by Michigan Civil Service. For further information, contact: Richard D. Budd, M.D., Northville State Hospital, 41001 Seven Mile Road, Northville, Michigan 48167. An Equal Opportunity Employer.

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**PHYSICIANS NEEDED IN NORTH CENTRAL OHIO.** Immediate openings in general practice and in internal medicine in rural area. Will provide space and arrangements. New hospital facilities. Contact Hardin County Medical Society, c/o Hardin Memorial Hospital, Kenton, Ohio 43326.

**EMERGENCY ROOM PHYSICIAN NEEDED.** July, 1973, Southwest Ohio. Established group to add 5th man. Excellent opportunity for a physician who is interested in immediate partnership without financial outlay. Reply Box 677, c/o Ohio State Medical Journal.

**WANTED:** Position available at once to join a well established Emergency Room Group, full time, at Deaconess Hospital of Cleveland. Please Contact: Walter Pavluk, M.D., 5500 Ridge Road, Parma, Ohio 44129. Telephone 216/884-1800.

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**OB-GYN WANTED** to associate with well-established, busy 38-year-old Junior Fellow doing over 500 deliveries/year in Portsmouth, Ohio. Share work and income from first day. Two modern fully approved hospitals in this pleasant Ohio University Branch College town. Please contact: John S. Temponeras, M.D., 3350 Indian Drive, Portsmouth, Ohio 45662. Tel. 614/354-2616 or 614/353-6220.

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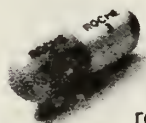
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**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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MAY • 1973  
VOL. 69 NO. 5

18 MAY 1973

# *The Ohio State* MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION



Henry G. Cramblett, M.D.

OSU College of Medicine  
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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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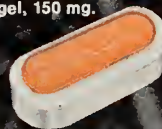
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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during December and January. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

|   |   |
|---|---|
| <b>ALLEN</b><br>Roque E. Teruel<br>Lima   | <b>LUCAS (Toledo)</b><br>Nasir Ali<br>Nicholas Bailas<br>Amrutha<br>Bhaktavathsalan<br>Stuart L. Billing<br>Jules J. Isaacson<br>Lucien E. Morris<br>Romeo M. Sogocio<br>Jose K. Yuan   |
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| <b>DARKE</b><br>Emil M. Gullia, Jr.<br>Greenville<br>Leroy Steinbrecker<br>New Madison                    | <b>MIAMI</b><br>Dean A. Landes<br>Troy  |
| <b>DELAWARE</b><br>Merry L. Obetz<br>Delaware   | <b>MONTGOMERY (Dayton)</b><br>Gideon S. Adegbile<br>Charles L. Bensonhaver<br>Gerald J. Brook<br>Stephen H. Dimlich<br>Jimmy L. Frazier<br>Rodrigo L. Jaballas<br>Suk Soon Lee<br>Robert W. Lipp, Jr.<br>Lolita L. Rana<br>Mohammad Ali Shahabi |
| <b>ERIE</b><br>Robert J. Lazaroni<br>Sandusky   | <b>ROSS</b><br>Naresh K. Parikh<br>Chillicothe<br>Carl G. Schowengerdt<br>Chillicothe   |
| <b>FAIRFIELD</b><br>Edwin R. Payne<br>Lancaster   |   |
| <b>HAMILTON</b><br>Jose R. Suarez<br>Cincinnati   |   |
| <b>LAKE</b><br>Ming Siung Hsu<br>Painesville  |   |
| <b>LICKING (Newark)</b><br>John P. Anderson, Jr.<br>Eduardo E. Yu<br>Imelda L. Yu                         |   |

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Fremont

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Canton  
Quirino B. Valeros  
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**WAYNE**  
Gerald W. Steiner  
Wooster

**WOOD**  
Mohammad Sidqi  
Bowling Green

\* \* \*

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during February and March. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

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Peebles  
Her-Ching Lin  
West Union

**ALLEN**  
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Lima

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Varalakshmi Dheenan

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Blanca Kent  
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James R. Magnussen  
John M. Rower

**GEAUGA**  
Vichai Duangjak  
Chardon

**HAMILTON (Cincinnati)**  
except as noted)  
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Donal S. Cullen  
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Robert Michael Gabel  
Robert N. Henderson  
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Jerrold Mayer Levin  
Milton M. Lieberthal  
Norbert Nissimov  
Yoichi Oikawa  
Sanyasi S. Raju  
G. James Samarco  
Rees William Sheppard  
Vishwanath M. Shetty  
John Joseph Smith  
Robert Charles Ufferman

**JEFFERSON**  
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Steubenville

**LAKE**  
Edwin V. Basquinez  
Mentor



## OSMA New Members (Contd)

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| LUCAS (Toledo)<br>M. Y. Ahmed<br>Armando B. Bautista<br>Mark Bohm<br>Donald B. Campbell<br>Shirley M. Ferguson<br>Kushala K. Hedge<br>Recto O. Natividad<br>Donald L. Warkentin | OTTAWA<br>David E. Crouch<br>Port Clinton<br><br>PORTAGE<br>Stephen J. Sveda<br>Ravenna<br><br>PUTNAM<br>Louis T. Chappell<br>Bluffton |
| MAHONING<br>Narcisco C. Domingo<br>Youngstown   | RICHLAND<br>Thomas H. Croghan<br>Mansfield<br>C. David Shook<br>Mansfield  |
| MARION<br>Andrew P. Klaus<br>Marion   | SENECA<br>George J. Padanilam<br>Fostoria  |
| MIAMI<br>Roger R. Goodenough, Jr.<br>Troy<br>Mazur Zarraby Isfahani<br>Piqua  | STARK<br>Shujauddin M. Ahmad<br>Canton<br>David G. Kundel<br>Alliance<br>Ronald A. Shubert<br>Canton                                   |
| MONROE<br>Donald R. Piatt<br>Woodsfield   | WASHINGTON<br>Curtis L. Dehmlow<br>Marietta  |
| MONTGOMERY<br>Hae Man Hwang<br>Dayton<br>Ferit I. Yavuz<br>Dayton   | WILLIAMS<br>Virgil N. Carrico<br>Bryan<br>Richard L. Hess<br>Bryan   |
| MUSKINGUM<br>David C. Reyes<br>Zanesville   |  |

## 'Family Physician' Scholarship Established in Toledo Area

The Toledo Chapter of the American Academy of Family Physicians (AAFP) has selected Donald Baker, a first year student at the Medical College of Ohio at Toledo to be recipient of the chapter's first scholarship award.

Baker, a graduate of Scott High School, holds degrees from the University of Toledo and Bowling Green State University. He served as assistant football coach at T.U. in 1969 and as youth coordinator for the Toledo Office of Economic Opportunity before applying for entrance to the Medical College.

Dr. John L. Culberson, vice-president of the chapter and chairman of the scholarship committee, said the \$400 award to Baker marks the first effort by Academy members in this area to provide financial aid to a student whose medical interests are directed toward family practice.

The local AAFP chapter proposes to furnish additional \$400 awards for each of Baker's three years at MCO. Also in each successive year, another student will be selected for the three-year scholarship, Dr. Culberson said, with the provision that the recipients maintain good grades and standing in their respective class.

The first award was presented at a dinner meeting in the Ramada Inn, Perrysburg.



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## Continuing Education Opportunities for Physicians in Ohio

**Surgical Seminars** — Medical College of Ohio at Toledo and Northwestern Ohio Institute for Continuing Medical Education; one hour a day, one day a week, for 88 weeks; dates on request.

**Clinical Days on Emergency Care** — 80 hours of instruction on 20 separate days, September to June; Medical College of Ohio at Toledo, 945 S. Detroit Ave., Toledo 43614.

**Introductory Course in Nuclear Medicine for Physicians** — Nuclear Medicine Institute, 6760 Mayfield Rd., Cleveland 44124; five-day courses; dates upon request.

**Postgraduate Laparoscopy Courses** scheduled approximately every six weeks at Fairview General Hospital, 18101 Lorain Ave., Cleveland 44111; for dates and details contact George P. Leicht, M.D., Chairman, Department of Ob-Gyn.

### May

**University of Cincinnati College of Medicine (CONMED)**—Eden and Bethesda Avenues, Cincinnati 45219:

**Velo-Pharyngeal Insufficiency**, May 3  
**General Surgery**, May 16-17

**Internal Medicine—Current Concepts of Clinical Problems**—Cosponsored by the American College of Physicians, May 21-25

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106:

**Organization and Administration in Anesthesiology**, May 5-6

**Advances in Dermatology**, May 9-10

**Cytogenetics, Noting Prenatal Diagnosis, Clinical Consideration and Counselling**—Sponsored by the Cleveland Society of Obstetricians and Gynecologists at the Marriott Inn, 4277 West 150th

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

St., Cleveland, May 9, educational forum starting at 3:00 p.m.; Cecil Jacobsen, M.D., and Neil McIntyre, M.D., guest speakers; dinner and evening meeting, 7:00 p.m., **Recent Advances in Reproductive Genetics** by Dr. Jacobsen. Contact, Kathryn E. Hoffman, M.D., 2060 E 9th St., Cleveland 44115.

**Cardiology Highlights** — Akron City Hospital, 525 Market St., May 9, 9:00 a.m.; Thomas R. Riley, M.D., Coordinator.

**Ohio State Radiologic Society Annual Meeting**; all physicians invited to attend; Christopher Inn, Columbus, May 11-13; scientific session will deal principally with radiology of the gastrointestinal tract; for copy of program or other information contact James V. Blazek, M.D., Radiology Department, Riverside Methodist Hospital, 3545 Olentangy River Road, Columbus 43214.

**Endoscopy and Gastrointestinal Bleeding**—Youngstown Hospital Association, South Unit, May 17, 8:00 a.m.; Dr. Reed T. Keller, of Case Western Reserve University, guest lecturer.

**Research in Esophageal Repair**—Veterans Administration Center, 4100 W. Third Street, Dayton 45428; May 18; 2:30 p.m.; Dr. Charles L. Cogbill; **A New Approach in the Treatment of Esophageal Perforation**, Dr. Krishna V. S. Rao; **A New Treatment for Esophageal Stricture**, Dr. Mahood Mir.

## Educational Opportunities in Ohio — *Continued*

**Interaction of Drugs**—Veterans Admin. Center, 4100 W. Third St., Dayton 45428; May 18 from 2:30 to 4:00 p.m.; speaker will be Barrett H. Bolton, director of education for the Department of Medicine at Miami Valley Hospital, Dayton. Contact Hassan Mehbod, M.D., at the VA Center.

**Carcinoma of the Lung**—The Heberding Memorial Lecture at the Youngstown Hospital Association, South Unit, Friday, May 18, at 8:00 p.m., and Saturday, May 19 at 9:00 a.m. Guest professor, Philip Rubin, M.D., professor and chairman of Radiation Therapy, Strong Memorial Hospital, Rochester, N.Y.

**Internal Medicine, Current Concepts of Clinical Problems**—Sponsored by the American College of Physicians and the University of Cincinnati College of Medicine; May 21-25 at the Medical Center, Cincinnati.

**Visiting Professor Program** — Akron City Hospital, 525 Market St., May 22; visiting professor, William C. Roberts, M.D., chief, Section on Pathology, National Heart and Lung Institute.

**Third Annual Radiology Seminar**—Radiology Service, Veterans Administration Center, 4100 W. Third St., Dayton 45428, May 23; admission by advance registration only; contact Emil Gutman, M.D.

**General Surgery** — Akron City Hospital, 525 Market St., May 24-25; visiting professor, Theodore Drapanas, M.D., Department of Surgery, Tulane University School of Medicine.

**Digitalis and Injured Heart**—Youngstown Hospital Association, South Unit, May 28, 4:00 p.m.; Drs. W. H. Bunn, Jr., and R. D. Arnott.

**Refresher Course in Diagnostic Roentgenology, 15th Annual** — Radiology Dept., University of Cincinnati College of Medicine, under direction of Benjamin Felson, M.D., May 29 - June 2; for radiologists and radiology residents; contact Dr. Harold B. Spitz, Dept. of Radiology, Cincinnati General Hospital, Cincinnati 45229.

### June

**Laparoscopies**—Youngstown Hospital Association; June 7, 8:00 p.m. Guest Professor, E. P. Peterson, M.D., Women's Hospital of the University of Michigan Medical Center.

**Visiting Professor Program** — Akron City Hospital, 525 Market St., June 14-15; Beverley T. Mead, M.D., chairman, Department of Psychiatry, Creighton University School of Medicine.

### August

**Ohio Academy of Family Physicians Annual Scientific Assembly** — Sheraton-Columbus Motor Hotel, downtown Columbus, August 3-5. For details, contact the Academy at 4075 N. High St., Columbus 43214.

**Fifth Semiannual Short Course on Laser Safety**—Sponsored by the Medical Laser Laboratory and the office of Continuing Medical Education (CONMED) of the University of Cincinnati; August 6-10; at the University; tuition \$325; course director, R. James Rockwell, Jr., for details contact CONMED, 114 Medical College, Cincinnati 45219; phone 513/861-8000, Ext. 405.

— More Educational Opportunities on Next Page —



## St. Elizabeth Hospital, Youngstown, Announces Continuing Education Courses

**Endocrinology Conferences:** Stein Leventhal Syndrome, Dr. Jung, May 5; **Diabetis Mellitus with Pregnancy**, Dr. Jung, May 12; **Hypoglycemia**, Dr. Jung, May 19; **Gout**, Dr. Jung, May 26.

**Tumor Conferences (Medicine):** **Pituitary Tumors**, George River, M.D., May 3; **Carcinoma of Pancreas**, May 10; **Brain Tumors**, Dr. River, May 17; **Primary Liver Cell Carcinoma (Hepatoma)**, Dr. Riber, May 24; **Lymphoma-Leukemia**, Dr. River, May 31.

**Dept. of Anesthesia: Pediatric Anesthesia**, Dr. Salcedo, May 3; **Principles of Cardiopulmonary Resuscitation**, Dr. Chen, May 10; **Complications and Accidents During Anesthesia**, Dr. Chen, May 17; **Diagnostic, Therapeutic and Anesthetic Nerve Block**, Dr. Salcedo, May 24; **Narcotics, Narcotic Antagonists and Management of Postoperative Pain**, Dr. Dziadzka, May 31.

**Dept. of OB-Gyn Visiting Professor Series:** **Histogenesis of Squamous Cell Carcinoma**, W. B. Wentz, M.D., May 3; **Chemotherapy in Gynecological Malignancy**, Dr. Wentz, May 10; **Clinical Pathological Correlation Session**, Dr. Wentz, May 17; **Malignant Ovarian Tumors and Treatment**, Delbert Booher, M.D., May 31.

**Dept. of Surgery Grand Rounds: Management of Ureteral Injury**, Demetrios J. Dallis, M.D., May 3; **Management of Burn**, Robert Hritz, M.D., May 10; **Hodgkins Disease for Surgeons**, Rashid Abdu, M.D., May 17; **Hyperparathyroidism and Parathyroid Adenoma**, Felix Pesa, M.D., May 24; **Peptic Ulcer Disease**, Dr. Dallis, May 31.

**Family Practice: Anorectal Problems for the Generalist**, Dr. J. K. Herald, May 4; **Management of Anemia**, Dr. J. Altier, May 11; **Cardiac Murmurs in School Children**, Dr. K. Wegner, May 18; **Selection and Use of Oral Contraceptives**, Drs. J. Buckley and S. Chiasson, May 25.

**Dept. of Pediatric CORE Conference:** **Asthma in Children**, Kurt Wegner, M.D., May 2; **Antibiotics in Pediatric Practice**, Dr. Wegner, May 16; **Anemia in Childhood**, Dr. Wegner, May 30.

**The Clinical Examination: Basic Course in Auscultation, Part I**, May 9 **Part II**, May 23, L. P. Caccamo, M.D.

**Dept. of Medicine Hematology Conferences:** **Hereditary Spherocytosis**, Dr. Jensen, May 7; **Chronic Symphocytic Leukemia**, Dr. Westerman, May 21.

**Dept. of Medicine Grand Rounds: Chronic Active Hepatitis**, Dr. Gregori, May 8; **Drowning**, Dr. Johnson, May 15; **Diverticulosis of Colon**, Dr. Gaylord, May 22; **CPC**, Drs. Saadi and Taylor, May 29.

**Dept. of Medicine Visiting Professor Series:** **G. I. Bleeding**, Bertram Fleshler, M.D., May 10; **Trichinosis**, Edward B. Rothram, May 24.

**G. I. Conferences: Villous Adeno of Colon**, Dr. Gregori, May 8; **Acute Pancreatitis**, Dr. Gaylord, May 15; **Carcinoma of Pancreas with Metastasis**, Dr. Gregori, May 22; **Duodenal Ulcer**, Dr. Gaylord, May 29.



## Sally's back in sew biz! After an arthritic flare-up.

**Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before treatment and keep them under close supervision. Obtain a detailed history, and complete blood and laboratory examination (complete hematology, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients who are responsive to routine measures, contrast patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substituting capsules for tablets if dyspeptic symptoms. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (such as blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other signs of intestinal ulceration or hemorrhage, skin rash, significant weight gain or edema. A one-week trial is adequate. Discontinue in the absence of a therapeutic response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, ankylosing spondylitis.

**Contraindications:** Children 14 years or less; senile psychosis or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypothyroidism; thyroid disease; systemic edema, parotitis and salivary gland enlargement due to the polymyalgia rheumatica and temporal arteritis; receiving other potent chemotherapeutic agents or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, extent of concomitant diseases, and concurrent potent therapy affect incidence of toxic reactions. Carefully monitor and observe the individual patient, especially the elderly (forty years and over) who have decreased susceptibility to the toxicity of the drug. Use with caution in first trimester of pregnancy. Nursing mothers. Drug may appear in cord blood. Serious, even fatal, blood dyscrasias,

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Each capsule contains:  
100 mg phenylbutazone USP  
100 mg dried aluminum hydroxide gel USP  
150 mg magnesium trisilicate USP

If it doesn't work in a week, forget it.

including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug. **Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the elderly) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis,

epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement (B)98-146-070-G

**Serious side effects do occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings, contraindications and adverse reactions.**

For complete details, including dosage, please see full prescribing information.

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# What should a medication for sleep be expected to provide?



**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or

recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years

of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with



## Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

## Sleep with consistency

Dalmane (flurazepam HCl) has been shown to be consistently effective even during consecutive nights of administration. Thus there is little likelihood for the need to increase dosage to maintain therapeutic effect.

Dalmane is in a class by itself. Not a narcotic, barbiturate or methaqualone, Dalmane is the only available benzodiazepine specifically indicated for insomnia.

## Sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. In most instances when adverse reactions were reported they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity agent proved effective and relatively safe for relief of insomnia.

# DALMANE<sup>®</sup>

(flurazepam HCl)

## When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage

(15 mg may suffice in some patients).

One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

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Nutley, New Jersey 07110

depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia, falling have occurred, particularly in elderly or debilitated patients. Severe ataxia, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech,

confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances. **Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined. **Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.

## "Prescription drugs – who should determine the maker?"

### Dispenser of Medicine

Clifton J. Latiolais  
President  
American  
Pharmaceutical  
Association



### Maker of Medicine

C. Joseph Stetler  
President  
Pharmaceutical  
Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

#### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

#### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

#### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree, puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25



ould be an obligation of medical  
practice...

"Medical societies ought to con-  
tinue campaigns to point  
out the substantial savings that could  
be realized thru deductible insurance  
protection for catastrophic ill-  
nesses. At the very least, they should, in  
patients' interest, question the  
practices of any insurance organization  
that raises health care costs by forc-  
ing policyholders to buy insurance  
they may not need or want and prob-  
ably won't ever use.

"Too many doctors are indiffer-  
ent to the economic consequences of  
their decisions. Too many, for ex-  
ample, habitually hospitalize patients  
for the convenience of the MD. It's  
sense to deny such habits exist...

"Doctors, thru their medical so-  
cieties, have unhesitatingly appealed  
to their patients for support in the  
fight against government interference  
in the private practice of medicine.  
The public in the past has re-  
sponded. It's time the American Med-  
ical Association and state and local  
medical societies paid off the debt by  
taking decisive action to hold down the cost  
of medical care."

#### Cost of Drugs

Insurance rates and hospital  
charges are only two factors in health

care costs. The cost of drugs—both  
prescription and nonprescription—is  
another.

And when it comes to drug  
costs, the nation's pharmacists are  
*concerned*. Through their national  
professional society, the American  
Pharmaceutical Association, pharma-  
cists are advising the public to use  
nonprescription medication cau-  
tiously and conservatively, and to seek  
the advice of their pharmacist before  
selecting or purchasing such drugs.

#### Outdated Laws

The pharmacist also is aware  
that when it comes to prescription  
drugs, often he has an even greater  
opportunity to reduce the cost to the  
patient—with no sacrifice in the qual-  
ity of the medication dispensed. But  
in many states, outdated and anti-  
quated laws prevent the pharmacist  
from engaging in drug product selec-  
tion. "Drug product selection" simply  
means that the pharmacist functions  
in the patient's interest by con-  
sciously choosing, from the multiple  
brands available, a low-cost quality  
brand of the specific drug to be dis-  
pensed in response to the physician's  
prescription order.

Much *misinformation* has been  
purposely spread by those who stand  
to gain financially by maintaining

high drug costs to the public. An en-  
dless stream of propaganda has ema-  
nated from the drug industry in an  
effort to persuade the medical profes-  
sion that these so-called anti-substitu-  
tion laws should be retained. And as  
long as these laws are retained, the  
drug industry will continue its current  
marketing practices which contribute  
unnecessarily to high drug costs to  
patients. These practices also are in-  
viting government agencies to expand  
their restrictive controls on physi-  
cians and pharmacists.

#### APhA Efforts

As pharmacists, we are con-  
cerned about health care costs. We  
hope that every physician shares our  
concern on this vital issue, and will  
give his personal support to the con-  
structive efforts APhA has undertaken  
in the interest of all patients.

*(For a complete discussion of  
drug product selection, you are invited  
to request a free copy of the "White  
Paper on the Pharmacist's Role in  
Product Selection" from: American  
Pharmaceutical Association,  
2215 Constitution Avenue, N.W.,  
Washington, D.C. 20037.)*

30 drugs that he selects to treat the  
majority of conditions encountered in  
his practice. Moreover, the physi-  
cian's choice of a specific brand is  
based on his knowledge of the pa-  
tient's medical history and current  
condition, and his experiences with  
the particular manufacturer's  
product.

Some substitution proponents  
have argued that the dispensing of a  
prescription is a simple two-party  
transaction between the pharmacist  
and the patient, and that a substitut-  
ing pharmacist may avoid even a  
technical breach of contract by simply  
notifying the patient that he is making  
the substitution. I would judge that  
few courts would be sympathetic  
toward a pharmacist who substituted  
without physician approval and who  
undertook a legal defense that seeks  
to make the patient responsible for  
the pharmacist's actions.

#### Reduced Prescription Prices?

Substitution advocates are  
suggesting to the consumer, and par-  
ticularly the consumer activist, that  
reduced prescription prices could  
follow legalization of substitution.  
We have seen absolutely no evidence  
to justify this claim. To the contrary,  
experience in Alberta, Canada, where  
substitution is authorized, suggests

the opposite.

Many pharmacists understand-  
ably are concerned about the cost of  
maintaining multiple stocks of similar  
products. While there is no doubt that  
inventory costs rise when additional  
brands are stocked, it would be inter-  
esting to know how much they rise,  
and how many pharmacists actually  
stock *all* brands—of, say, ampicillin  
or tetracycline—or how long they  
keep "slow moving" products on their  
shelves before they are returned for  
credit. To ask that the industry elimi-  
nate multiple sources is to ask com-  
petitors to stop competing.

#### Drug Substitution—A License for the Unethical

Anti-substitution repeal would  
favor "corner cutting" pharmacists  
and manufacturers. For them, free  
substitution would be not a right, but  
a license. As an aftermath, it is quite  
likely that the confidence of both phy-  
sicians and patients in the profession  
of Pharmacy would be eroded, as  
revelations about the unconscionable  
behavior of an undisciplined few were  
magnified in the press or in profes-  
sional circles.

#### Summary

In short, what the American  
Pharmaceutical Association advo-

cates as a broad-spectrum panacea  
looks to us to be not only a minority  
view (advocacy of substitution is by  
no means a uniform policy in Phar-  
macy), but also an extraordinarily  
costly and ineffective remedy, whose  
side effects are odious. We believe  
(1) that an impressive majority of  
pharmacists prefer to work with  
Medicine and with industry, for the  
consumer, and for the general good,  
(2) that they seek the privilege to sub-  
stitute when the patient might gain  
and when the patient's doctor agrees,  
and (3) that they seek to work for the  
resolution of genuine grievances  
openly and professionally.

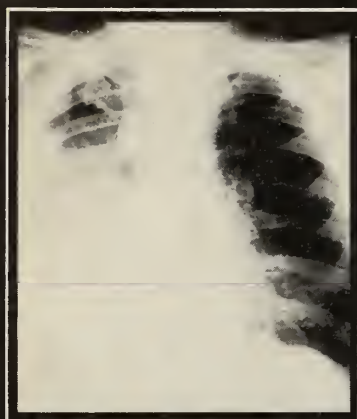
*(For amplification of PMA views,  
please write for our booklet, "The  
Medications Physicians Prescribe:  
Who Shall Determine the Source?"  
It is available from: Pharmaceutical  
Manufacturers Association, 1155  
Fifteenth Street, N.W., Washington,  
D.C. 20005.)*

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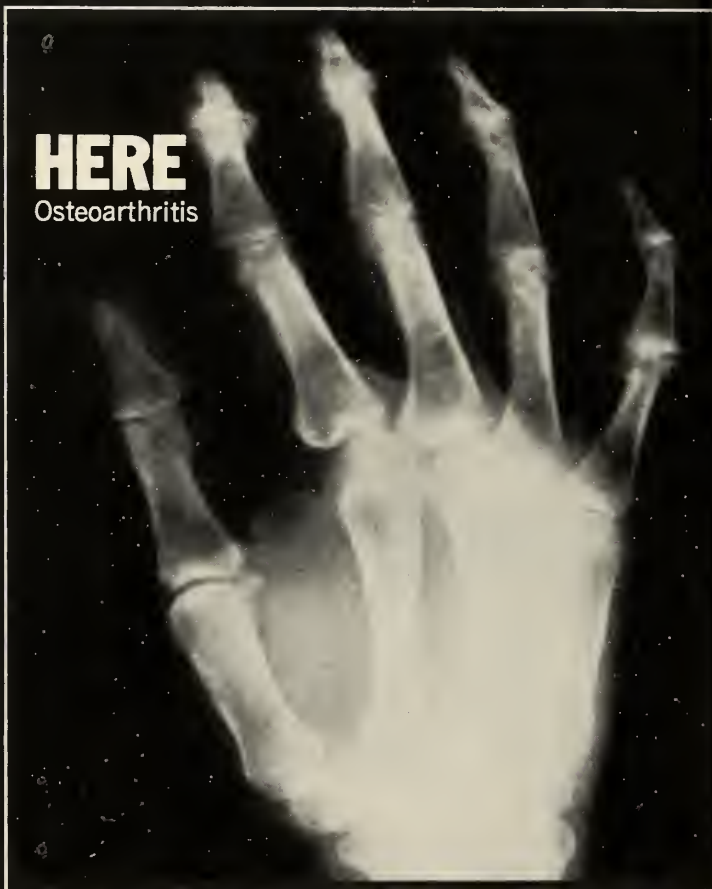
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Codeine **No. 3**, codeine  
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caffeine gr. ½.



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## MD's in the News

Dr. Charles H. Rammelkamp, Cleveland, is a member of the board of the Robert Wood Johnson Foundation, sponsors of a \$5.9 million clinical scholar program. The program is aimed at young men and women who have recently received their M.D. degrees and are expected to assume key roles in planning, management, and evaluation of community health systems, government-sponsored health programs, and health sciences education.

Dr. William D. Patton, Middletown, was honored recently with the Governor's Award and with a citation from the Ohio House of Representatives for his humanitarian activities in the community. The presentations were made at a testimonial gathering at which a monetary gift from community friends also was given to Dr. Patton.

Dr. Trent W. Smith, of Columbus, associate professor of otolaryngology at Ohio State University, was named president-elect of the American Academy of Facial Plastic and Reconstructive Surgery at the organization's ninth annual scientific meeting held in St. Louis. He is a former president of the American Society of Facial Plastic Surgery and a diplomate of the American Board of Otolaryngology.

Dr. Nino M. Camardese, of Norwalk, for the second time has been accorded the George Washington Honor Medical Award by the Freedoms Foundations. The Foundation met at Valley

Forge, Pa., for its 24th annual awards program. Dr. Camardese, a naturalized American Citizen who spent his boyhood under a fascist regime, is an outspoken advocate of the American way of life and especially of preservation of the physician-patient relationship in medicine.

Some 350 people attended a testimonial dinner in honor of Dr. John P. Smarella, native of Steubenville and physician there of long standing as well as former Jefferson County coroner. He was presented "The Cavaliere of the Order of Merit of the Republic of Italy" medal and scroll by Italian Consul Mario Anziano, of Cleveland. The honor is bestowed on Americans of Italian ancestry who have distinguished themselves by their humanitarian activities.

An eye bank has been established at the Medical College of Ohio at Toledo, to serve some 20 counties in northwest Ohio. Monetary gifts from the Lions Club and the public will support the program.

The University of Kentucky College of Medicine will present a program on drugs and techniques in anesthesia, June 1-2; fee \$50; contact Ronald D. Hamilton, M.D., Director of Continuing Education, University of Kentucky College of Medicine, Lexington, Ky. 40506.



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## OSMA Staff Member Retires



It was a quiet luncheon at the University Club in downtown Columbus, but it marked the climax of a full and faithful career in the Headquarters Office of the Ohio State Medical Association.

In fact, Hazel Winzenried established an all-time record for longevity on the State Association staff — some 36 years and five months — before her retirement on January 31.

The above photograph was taken at the luncheon and shows Miss Winzenried receiving a token of appreciation from the Association and the staff, presented by Hart F. Page, OSMA Executive Director, who commended her on behalf of the Association for her long and faithful service. The entire staff of the Association joined Mr. Page in a tribute to her and in wishing her well in her future plans.

Also joining her at the testimonial luncheon were her sister-in-law, Mrs. Louise Winzenried, who came from her home in Florida for the occasion, and her nieces and nephews from the Central Ohio area. Also present were Charles S. Nelson and George (Scottie) Saville, retired Executive Secretaries of the Association, and Miss Florence Okert and Mrs. Edna Latimer, retired members of the staff.

Miss Winzenried joined the staff in the mid-1930's. Since then she has witnessed a phenomenal growth in the Association's membership and activities.

During her earlier years with the Association, she assumed many responsibilities including work on *The Journal*. In more recent years, her principal activities revolved around the Annual Meeting, the House of Delegates and The Council.

# Columbus Physician Named Dean of OSU College of Medicine

THE BOARD OF TRUSTEES of Ohio State University has named Dr. Henry G. Cramblett, of Columbus, as dean of the College of Medicine, effective July 1. The action was announced following an early April meeting of the Board. The office of dean became vacant when Dr. John A. Prior resigned from that post.



Dr. Cramblett

In announcing the appointment, Board President Harold L. Enarson said: "Dr. Cramblett has an excellent reputation as teacher, researcher, practicing physician, and as a leader in medical affairs locally and nationally. He brings to an extraordinarily difficult and demanding assignment all the requisite qualifications — professional competence and sensitive concern for improved medical care, an acute sense of the possible in medical research, impressive energy and drive, and an intimate familiarity with the College of Medicine. He also has the support and respect of colleagues in the College, the University and the medical profession."

Dr. Cramblett is professor of pediatrics and chairman of the Department of Microbiology at Ohio State, with headquarters at Children's Hospital, Columbus, and executive director of the Children's Hospital Research Foundation.

He was appointed to the State Medical Board in 1970 to fill three years of an unexpired term, and was named secretary of the Board in 1971. The State Medical Board is the state agency charged with the responsibility of licensing physicians and

other practitioners of the healing arts in Ohio and enforcing the law as it applies to the healing arts.

In 1972 he was named to the FLEX Examination Committee and to the American Board of Medical Specialists.

Among appointments, he has served as secretary of the Faculty, OSU College of Medicine, and on the OSU Research Council, and OSU Graduate Council, and the Clinical Research Fellowship Committee of the National Institutes of Health, and as consultant to the Seminar Services Division of the National Communicable Disease Center.

Dr. Cramblett was born in Scio and received his early education in the Harrison County community schools. He graduated Magna Cum Laude from Mount Union College, and was pledged to Psi Kappa Omega Scholastic Fraternity. Other collegiate honors included affiliation with Phi Sigma (Biology) and Alembroic (chemistry). He received his M.D. degree from the University of Cincinnati College of Medicine in 1953 and again earned several honors, among them the Eben J. Carey Award in Anatomy, the Stella Feis Hoffheimer Scholastic Award, and the pledge to Alpha Omega Alpha.

Dr. Cramblett took his internship in medicine at Boston City Hospital on the Harvard Medical Service. Before coming to Columbus in 1964, he was successively resident in pediatrics at Children's Hospital, Cincinnati; chief resident and instructor in the Department of Pediatrics, State University of Iowa; assistant professor at the same institution; associate professor of pediatrics, associate in pathology and microbiology, and director of the Virology Laboratory, Bowman Gray School of Medicine.

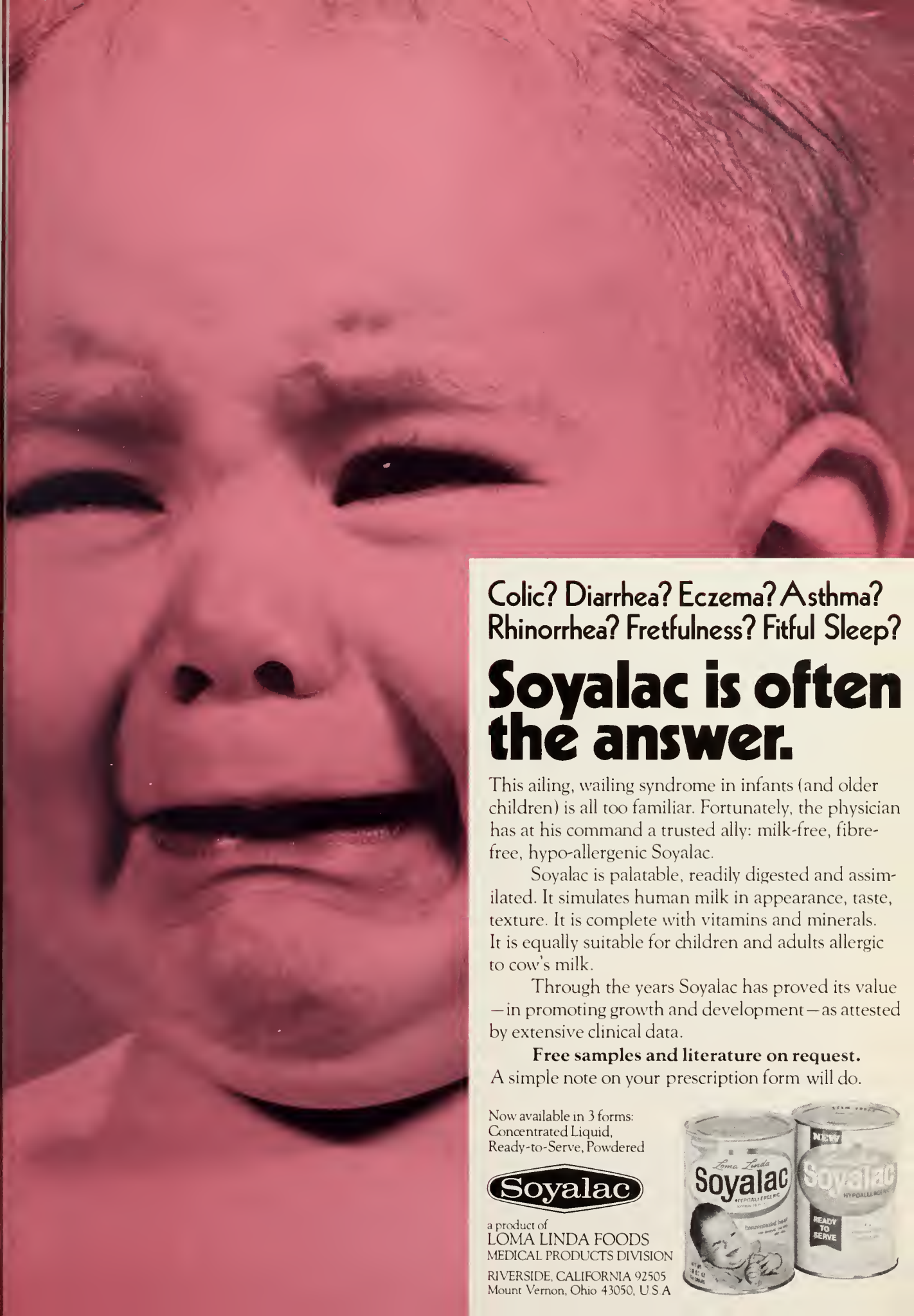
In addition to the honors mentioned, Dr. Cramblett is affiliated with numerous professional organizations, among them the Ohio State Medical Association and the American Medical Association.

\* \* \*

## Reappointed to State Medical Board

As this issue of *The Journal* was going to press, information was received that Governor John J. Gilligan had reappointed Dr. Henry G. Cramblett to the State Medical Board of Ohio for an additional seven-year term. He was first appointed to the Board in 1970 to fill part of an unexpired term.





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Soyalac is palatable, readily digested and assimilated. It simulates human milk in appearance, taste, texture. It is complete with vitamins and minerals. It is equally suitable for children and adults allergic to cow's milk.

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# Obituaries

---

**Jack Charles Berno, M.D.**, Chillicothe; Western Reserve University School of Medicine, 1945; aged 52; died March 18; member of OSMA, and AMA; Fellow, American College of Surgeons; diplomate, American Board of Surgery; practicing physician and surgeon in Chillicothe for a number of years; veteran of World War II.

**Robert Eugene Bowsher, M.D.**, Midland, Mich.; Ohio State University College of Medicine, 1939; aged 59; died March 16; practitioner for many years in Midland and recently director of medical education at Midland Hospital; veteran of World War II.

**Cornelius Joseph Cassidy, M.D.**, New Bavaria; Western Reserve University School of Medicine, 1926; aged 79; died March 27; member of OSMA, AMA and American Academy of Family Physicians; practitioner for some 40 years in Parma before his retirement in 1968.

**Wilbur Louis Davis, M.D.**, Martins Ferry; University of Cincinnati College of Medicine, 1922; aged 76; died March 23; member of OSMA, AMA, and American Geriatrics Society; practitioner of long standing in Martins Ferry and recently medical officer of the Veterans Regional Office in Wheeling; veterans of World War I.

**Charles Ross Deeds, M.D.**, Hendersonville, N.C.; Eclectic Medical College, Cincinnati, 1916; aged 82; died March 12; former member of OSMA; practitioner in Canton from 1920 to 1927, and in Cincinnati until 1948.

**Edwin WilliamENZ, M.D.**, Cincinnati; Medical College of Ohio, Cincinnati, 1907; aged 88; died March 10; member of OSMA and AMA; retired in 1955 after practicing for 48 years in Cincinnati.

**Wayne Clifford Estes, M.D.**, Cleveland; University of Texas Medical Branch, Galveston, 1920; aged 79; died February 22; member of OSMA and AMA; practitioner of long standing in Cleveland before his retirement; veteran of World War I.

**Robert Lee Faulkner, M.D.**, Willoughby; Johns Hopkins University School of Medicine, 1923; aged 74; died March 23; member of OSMA, AMA, American Association of Obstetricians and Gynecologists; American Gynecological Society;

Fellow, American College of Obstetricians and Gynecologists, and the American College of Surgeons; diplomate, American Board of Obstetrics and Gynecology; practitioner of long standing in Cleveland and formerly on the faculty of Case Western Reserve University School of Medicine. Among survivors are his son-in-law and daughter, Dr. and Mrs. Ronald B. Golden.

**Abram Ernest Handy, M.D.**, Cleveland Heights; Health Sciences Division of Virginia Commonwealth, 1943; aged 57; died March 24; member of OSMA, AMA, and Radiological Society of North America; Fellow, American College of Radiology; diplomate, American Board of Radiology; practitioner of long standing in the Cleveland area; veteran of World War II.

**Laurence M. Ihle, M.D.**, Galena; Ohio State University College of Medicine, 1932; aged 75; died March 4; member of OSMA; practitioner in Delaware County since 1933.

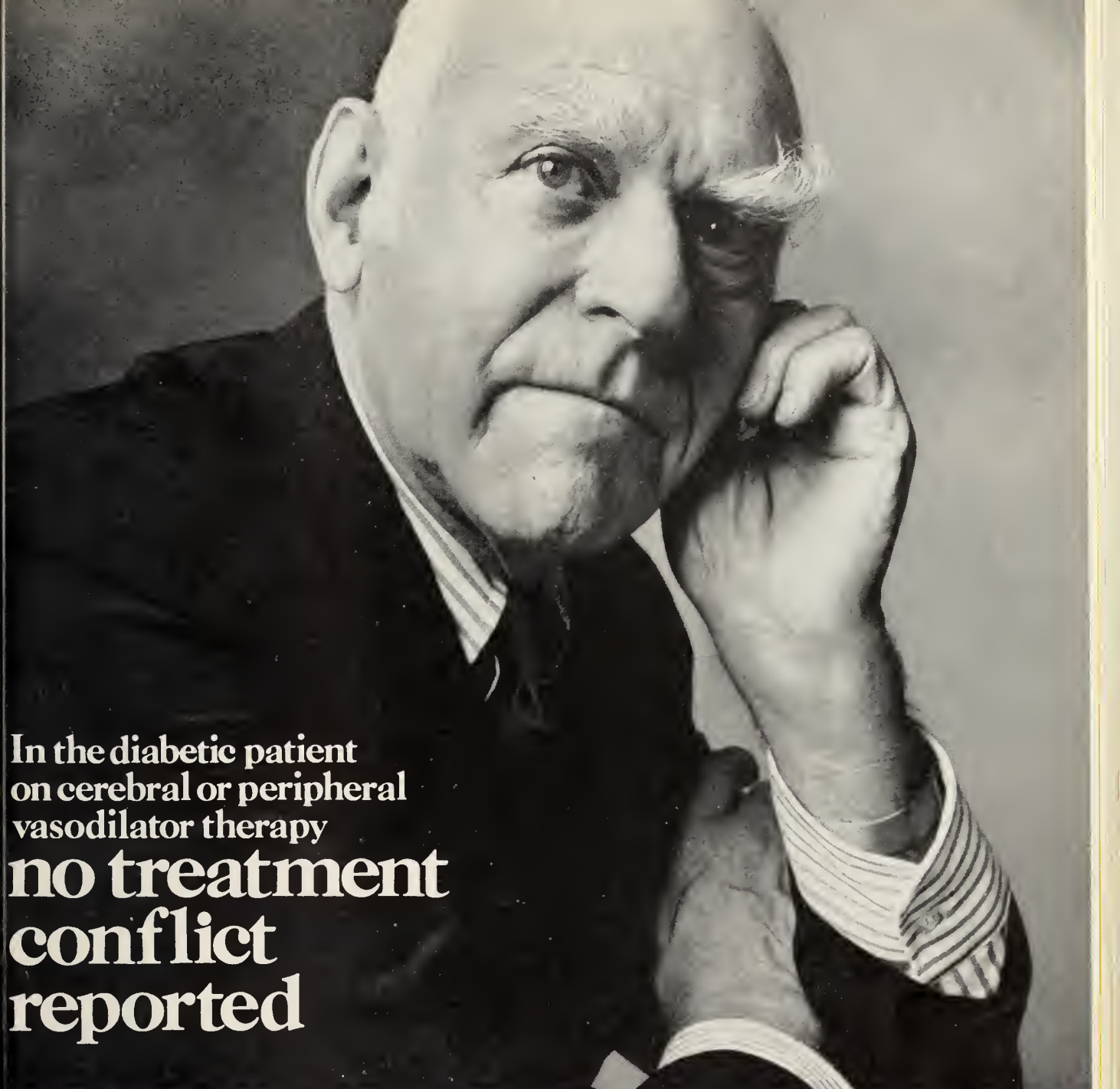
**Benjamin Franklin Lee, M.D.**, Wilberforce; Meharry Medical College School of Medicine, 1949; aged 63; died March 7; member of OSMA and former member of AMA; general practitioner of long standing in the Wilberforce area and director of the Central State University Health Service.

**Claude A. McCollough, M.D.**, Salineville; Ohio State University College of Medicine, 1923; aged 76; died February 26; member of OSMA and AMA; native of Salineville and practitioner in the Columbiana County area for virtually all of his professional career; veteran of World War I.

**Ralph Snyder Maurer, M.D.**, Cleveland; Western Reserve University School of Medicine, 1928; aged 71; died January 26; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner of long standing in the Cleveland area.

**Thomas A. Minahan, Jr., M.D.**, Hubbard; Cleveland-Pulte Medical College, 1913; aged 81; died February 27; member of OSMA and AMA; practitioner in the Trumbull County community since 1914 and former Trumbull County health commissioner; veteran of World War I.

**Bristow C. Myers, M.D.**, Lorain; Meharry Medical College School of Medicine, 1933; aged



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vasodilator therapy  
no treatment  
conflict  
reported**

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**(ISOXSUPRINE HCl)**  
**the compatible vasodilator**

**INDICATIONS:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

- no interference with diabetic control . . . does not alter carbohydrate metabolism.<sup>1</sup>

- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.

There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**DOSAGE AND ADMINISTRATION:** 10 to 20 mg. three or four times daily.

**CONTRAINDICATIONS AND CAUTIONS:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**ADVERSE REACTIONS:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**SUPPLIED:**

Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose  
20 mg.—bottles of 100, 500 and Unit Dose

**REFERENCE:** 1. Samuels, S. S., and Shaftel, H. E.:  
J. Indiana Med. Ass. 54:1021-1023 (July) 1961.

**Mead Johnson**  
LABORATORIES

**COMPOSITION:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

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65; died March 18; member of OSMA, AMA, and the American Academy of Family Physicians; practitioner in the Lorain area for 38 years; past president of the Lorain County Medical Society and the local organization of family physicians. Among survivors is a brother, Dr. Govan A. Myers, of Cleveland.

**William Kinsey Neeld, M.D., Xenia; Ohio** State University College of Medicine, 1966; aged 39; died March 10; member of OSMA and AMA; practicing physician in the Xenia area for six years; served in the U.S. Navy from 1962 to 1966.

**Lorenzo Dow Nelson, M.D., The Plains; Ohio** State University College of Medicine, 1908; aged 86; died February 28; former member of OSMA; native of Athens County and practitioner there for virtually all of his professional career; veteran of World War I.

**Bela A. Tapolczay, M.D., Cleveland; medical** degree from Elizabeth University, Hungary, 1933; aged 67; died January 25; member of OSMA and AMA; former practitioner in Budapest and resident of this country since about 1950; practitioner in the Cleveland area for several years.

**Everett Raymond Thomas, M.D., Poland; Western Reserve University School of Medicine,** 1916; aged 84; died March 5; member of OSMA and AMA; practitioner in the Poland-Youngstown area for more than 50 years, specializing in pediatrics; physician for the Youngstown public schools for 28 years; veteran of World War I.

**John H. Underwood, M.D., Canton; University of Maryland School of Medicine,** 1920; aged 79; died March 17; member of OSMA, AMA and the American Academy of Ophthalmology and Otolaryngology; diplomate, American Board of Otolaryngology; practitioner in Canton for 44 years.

**Richard N. Westcott, M.D., Cleveland; Harvard Medical School,** 1943; aged 54; died March 10; member of OSMA, AMA, and American Society of Internal Medicine; Fellow, American College of Physicians; associated since 1951 with the Cleveland Clinic Foundation where he was head of the electrocardiography section; veteran of World War II.

**Alexander Zasidatel, M.D., Montpelier; University of Graz School of Medicine, Austria,** 1953; aged 51; died March 14; member of OSMA and AMA; family practitioner in the Williams County community since 1963.

# new Santyl<sup>TM</sup> (collagenase) ointment

**Indications:** Santyl Ointment is indicated for debriding dermal ulcers and severely burned areas. In other types of necrotic skin lesions reports on the use of Santyl Ointment have been limited to clinical observations without controls.

**Contraindications:** Application is contraindicated in patients who have shown local or systemic hypersensitivity to Collagenase.

**Precautions:** The enzyme's optimal pH range is 7 to 8. Lower pH conditions have a definite adverse effect on the enzyme's activity, and appropriate precautions should be taken.

The enzymatic activity is also adversely affected by detergents and hexachlorophene and heavy metal ions such as mercury and silver which are used in some antiseptics. When it is suspected such materials have been used, the site should be carefully cleansed by repeated washings with normal saline before Santyl Ointment is applied. Soaks containing metal ions or acidic solutions such as Burow's solution should be avoided because of the metal ion and low pH. Cleansing materials such as hydrogen peroxide or Dakin's solution do not interfere with the activity of the enzyme. Debilitated patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia.

The ointment should be confined to the area of the lesion in order to avoid the risk of irritation or maceration of normal skin.

A slight erythema has been noted occasionally in the surrounding tissue particularly when the enzyme ointment was not confined to the lesion. This can be readily controlled by protecting the healthy skin with a material such as Lassar's paste.

Since the enzyme is a protein, sensitization may develop with prolonged use although none has been observed to date.

**Adverse Reactions:** Adverse reactions to Collagenase have not been noted when used as directed.

**Dosage & Administration:** Santyl Ointment should be applied once daily (or once every other day in the case of outpatients) in the following manner.

(1) Prior to application the lesions should be gently cleansed with a gauze pad saturated in normal saline, buffer (pH 7.0-7.5) or hydrogen peroxide to remove any film and digested material.

(2) Whenever infection is present, as evidenced by positive cultures, pus, inflammation or odor, it is desirable to use an appropriate topical antibacterial agent. Neomycin-Bacitracin-Polymyxin B (Neosporin) has been found compatible with Santyl Ointment. This antibiotic should be applied to the lesion in powder form or solution prior to the application of Santyl Ointment. Should the infection not respond, therapy with Santyl Ointment should be discontinued until remission of the infection.

(3) Santyl Ointment should be applied (using a wooden tongue depressor or spatula) directly to deep wounds, or, when dealing with shallow wounds, to a sterile gauze pad which is then applied to wound. The wound is covered with sterile gauze pad and secured with clear tape or Kling bandage.

(4) Crosshatching thick eschar with a #11 blade is helpful. It is also desirable to remove as much loosened detritus as can be done readily with forceps and scissors.

(5) All excess ointment should be removed each time dressing is changed.

(6) Use of the ointment should be terminated when sufficient debridement of necrotic tissue has taken place.

**Overdose:** Action of the enzyme may be stopped, should this be desired, by the application of Burow's solution U.S.P. (pH 3.6-4.4) to the lesion.

**How Supplied:** Santyl Ointment contains 250 units of Collagenase enzyme per gram of white petrolatum U.S.P. The potency assay of Collagenase is based on the digestion of undenatured collagen (from bovine Achilles tendon) at pH 7.2 and 37° C. for 24 hours. The number of peptides cleaved are measured by reaction with ninhydrin. Peptides released by a trypsin digestion control are subtracted. One net Collagenase unit will solubilize ninhydrin reactive material equivalent to 4 micromoles of Leucine.



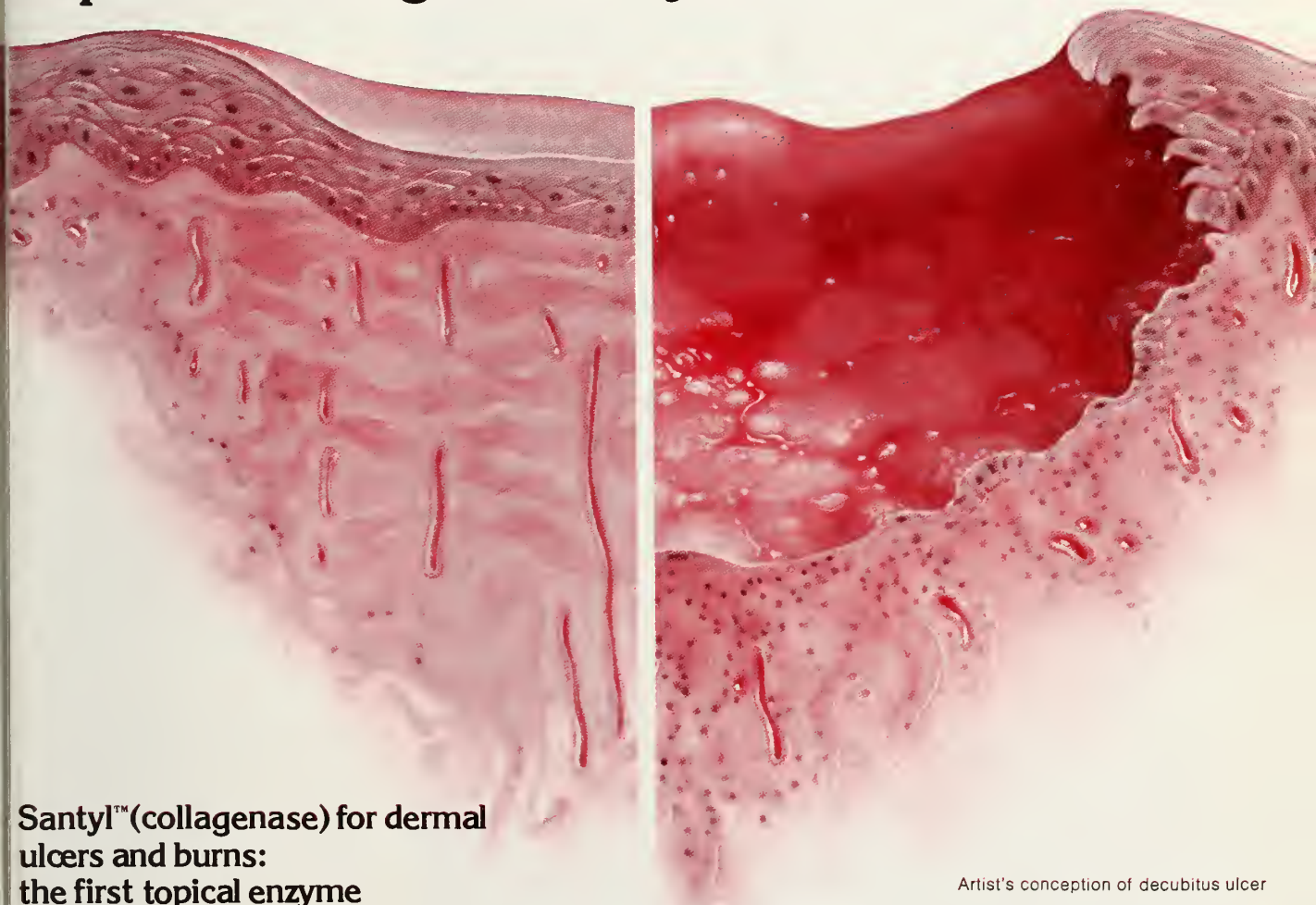


# <sup>new</sup> **Santyl**<sup>TM</sup> ointment (collagenase)

"...it may prove to be the drug of choice for wound debridement."

Varma A O et al: Surg. Gynec. Obstet. 136:281, Feb. 1973.

## To permit healing like this...you want to start like this.



Artist's conception of decubitus ulcer

### **Santyl<sup>TM</sup> (collagenase) for dermal ulcers and burns: the first topical enzyme**

#### ► to attack

native collagen, a substance that is ordinarily resistant to all common topical enzymes used in wound debridement

#### ► to dissolve

the strands of tissue that "anchor" necrotic debris and burn eschar to the wound surface

#### ► to effectively remove

the debris that hinders healing...with simple, once-a-day application

I treat patients with dermal ulcers and burns, and I would like to receive:

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- ☐ a free in-service training program on the use of Santyl.

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Nursing home or hospital affiliation \_\_\_\_\_

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City \_\_\_\_\_

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## Placidyl® (ETHCHLORVYNOL) Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated for short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and third trimester of pregnancy. Caution patients against possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY FOR A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported after long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuance of the drug. Drug dosage should be limited in elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients respond unpredictably to barbiturates or alcohol or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, syncope without marked hypotension. Transient blindness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, drowsiness, facial numbness, and allergic reaction manifested by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 305432



## Give us her nights.

Prescribe Placidyl. Chances are, we'll give her a good night's sleep.

Insomnia is often suffered by the elderly. Anxiety and agitation might be the cause. Or the effect. In time that can be determined. But tonight one fact is painfully clear: she needs sleep.

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(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)



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VOLUME 69

MAY 1973

NUMBER 5

## Tuberculin Testing

### A Pitfall to Avoid

SIDNEY I. LERNER, M.D.

THE TUBERCULIN SKIN TEST serves as the foundation for many tuberculosis control programs. Recommendations have been made that persons with a recent conversion to the Mantoux test, using 5 tuberculin units (5 TU) of purified protein derivative (PPD) tuberculin should receive prophylactic therapy with isoniazid for one year.<sup>1</sup> Recently, there have been increasing reports of isoniazid-associated liver disease. It is important that persons not be diagnosed falsely as converters and subjected to unnecessary concern and the potential risks associated with the long-term administration of isoniazid.

PPD tuberculin has been widely available for many years in tableted form for reconstitution. To reduce loss of potency by adsorption of tuberculo-protein onto glass or plastic, some manufacturers add 5 parts per million of Tween-80 to provide a stabilized solution of PPD tuberculin. The standard dose of 5 tuberculin units refers to bio-

logic activity; hence, one would expect that the various products could be used interchangeably.

The purpose of the present investigation was twofold: (1) to determine the reproducibility of response to 5 TU of tableted PPD tuberculin, and (2) to compare the response of tableted and liquid Tween-80 stabilized PPD tuberculin, in each case when 5 TU of the test antigen was administered simultaneously. The results would permit more accurate evaluation of future data from serial testing with either antigen, in particular the potential for the diagnosis of false conversion.

#### Methods

The routine tuberculosis surveillance program for employees at the Cincinnati General Hospital, Cincinnati, Ohio includes a 14 X 17 chest x-ray and a Mantoux tuberculin skin test using 5 TU of PPD tuberculin annually, in the absence of a positive reaction in the past.

From September 1969 to July 1971, there were 790 employees tested satisfactorily with 5 TU in 0.1 ml of reconstituted tableted PPD tuberculin.

Reprint requests to Kettering Laboratory, Eden and Bethesda Aves., Cincinnati, Ohio 45219 (Dr. Lerner).

Submitted September 19, 1972.

The antigen was simultaneously administered into the flexor surface of the right and left forearms using plastic disposable syringes with 27-gauge stainless steel needles. The PPD was reconstituted from different packages for each arm. It was never more than a few days old because of the number of tests routinely given, but was not necessarily used within 30 minutes after reconstitution. Injections were made immediately after the syringe was filled. Results were read after 48 to 72 hours and were recorded to the nearest millimeter of induration.

All injections and readings were performed by a specially trained nurse, who was instructed not to hesitate repeating or disqualifying an injection if she had any question about the technic and to record all readings objectively. The point was stressed that the PPD tuberculin was being tested rather than she.

When Tween-80 stabilized PPD tuberculin became available in the Cincinnati General Hospital and was recommended as a replacement for the tableted PPD, a second series was conducted for comparison. This was performed exactly as the first, with the exception that 5 TU in 0.1 ml of Tween-80 stabilized PPD was used in one arm and 5 TU in 0.1 ml of reconstituted tableted PPD was administered in the other. From May 1971 until April 1972, there were 429 persons satisfactorily tested in this way.

## Results

The reactions seen after 48 to 72 hours in the two arms in which 5 tuberculin units of tableted PPD was administered simultaneously are tabulated in Table 1. In 790 simultaneous tests there was not a single instance in which a significant difference in reaction was seen in the two arms. A significant difference is considered to be one in which one arm is interpreted as negative (0 to 4 mm) or doubtful (5 to 9 mm) and the other arm positive ( $> 9$  mm) with a difference so sufficiently great ( $> 6$  mm) that if the tests were

TABLE 1. Tableted PPD vs Tableted PPD

| mm Induration                   |                        | Number | %     |
|---------------------------------|------------------------|--------|-------|
| Arm A                           | Arm B                  |        |       |
| Tableted<br>PPD (5 TU)          | Tableted<br>PPD (5 TU) |        |       |
| Agreement                       |                        |        |       |
| 0                               | 0                      | 697    | 88.3  |
| 0                               | 1-4                    | 6      | 0.8   |
| 1-4                             | 0                      | 4      | 0.5   |
| 1-4                             | 1-4                    | 10     | 1.3   |
| 5-9                             | 5-9                    | 23     | 2.9   |
| >9                              | >9                     | 45     | 5.7   |
| Disagreement — not significant* |                        |        |       |
| 0                               | 5-9                    | 1      | 0.1   |
| 1-4                             | 5-9                    | 2      | 0.2   |
| 5-9                             | >9                     | 2      | 0.2   |
| Total                           |                        | 790    | 100.0 |

\* Difference under 6 mm

TABLE 2. Tableted PPD vs Stabilized PPD

| mm Induration                   |                                   | Number | %     |
|---------------------------------|-----------------------------------|--------|-------|
| Arm A<br>Tableted<br>PPD (5 TU) | Arm B<br>Stabilized<br>PPD (5 TU) |        |       |
| Agreement                       |                                   |        |       |
| 0                               | 0                                 | 352    | 82.1  |
| 0                               | 1-4                               | 3      | 0.7   |
| 1-4                             | 0                                 | 8      | 1.9   |
| 1-4                             | 1-4                               | 1      | 0.2   |
| 5-9                             | 5-9                               | 3      | 0.7   |
| >9                              | >9                                | 33     | 7.7   |
| Disagreement — not significant* |                                   |        |       |
| 0                               | 5-9                               | 2      | 0.5   |
| 5-9                             | 0                                 | 1      | 0.2   |
| 5-9                             | >9                                | 1      | 0.2   |
| Disagreement — significant†     |                                   |        |       |
| 0                               | >9                                | 11     | 2.6   |
| 1-4                             | >9                                | 3      | 0.7   |
| 5-9                             | >9                                | 10     | 2.3   |
| >9                              | 0                                 | 1      | 0.2   |
| Total                           |                                   | 429    | 100.0 |

\* Difference under 6 mm

† Difference over 6 mm

TABLE 3. Differences Related to Reaction Size

| Arm A<br>Tableted<br>PPD (5 TU) |        | Arm B<br>Stabilized<br>PPD (5 TU) |        | %<br>Significant<br>Difference |
|---------------------------------|--------|-----------------------------------|--------|--------------------------------|
| mm                              | Number | mm                                | Number |                                |
| 0                               | 368    | $> 9$                             | 11     | 3.0                            |
| 1-4                             | 12     | $> 9$                             | 3      | 25.0                           |
| 5-9                             | 15     | $> 9$                             | 10     | 66.7                           |

given in successive time periods a positive conversion would be interpreted.<sup>1</sup> Using the results in Arm A, 720 (91.1 percent) were negative (0 to 4 mm), 25 (3.2 percent) were doubtful (5 to 9 mm), and 45 (5.7 percent) were positive ( $> 9$  mm). Reactions in Arm B were 717 (90.8 percent), 26 (3.3 percent), and 47 (5.9 percent), respectively.

The results of the second series, in which 5 TU of tableted PPD was injected into one forearm and 5 TU of stabilized PPD simultaneously injected into the other, are presented in Table 2. Out of 429 tests with the tableted PPD 380 (88.6 percent) were negative, 15 (3.5 percent) doubtful, and 34 (7.9 percent) positive. To the stabilized PPD, 366 (85.3 percent) were negative, 5 (1.2 percent) doubtful, and 58 (13.5 percent) positive out of 429 tests given. Attention is directed to the number of cases in which a significantly greater reaction was seen in one arm as compared to the other. There were 24 out of 429 (5.6 percent) times when a significant positive reaction was recorded to the stabilized PPD at the same time that a negative or doubtful reaction was recorded to the same dose (5 TU) of the tableted PPD. In only one case was there a significant positive difference to the tableted PPD. This individual was retested three months



later and had 0 mm of induration to both tests. No explanation is apparent to explain the differences.

The frequency of significant positive differences to stabilized PPD tuberculin increased with larger reactions to the tableted PPD tuberculin. This relationship is summarized in Table 3. Out of 368 cases in which 0 mm of induration was observed to 5 TU of tableted PPD, there were 11 reactions > 9 mm to the simultaneously administered stabilized PPD for a significant positive difference of 3 percent. At 1 to 4 mm induration to the tableted PPD, there were 3 out of 12 with > 9 mm to the stabilized PPD for a significant difference of 25 percent, and 10 out of 15 at 5 to 9 mm for a significant difference of 66.7 percent.

### Comment

The tuberculin skin test is indispensable in the conduct of a well-controlled tuberculosis surveillance program. It can identify persons recently infected with tuberculosis prior to the appearance of changes on chest roentgenogram. Prophylactic isoniazid for recent converters may reduce their risk of developing active tuberculosis. As with all biologic tests on which therapeutic decisions are based, one must convince himself that the test is valid and reproducible. The present investigation was addressed only to the latter consideration. Other studies have evaluated the validity of the tuberculin skin test.

The results obtained in the first series of this study clearly demonstrate the excellent reproducibility of the skin test reaction to 5 TU of reconstituted tableted PPD in our hands. The variability one may expect, based on the reported adsorption to tuberculoprotein onto glass soon after its reconstitution, was not evident.<sup>2</sup> The right and left arm received PPD reconstituted from separate vials with no attempt being made to assure that they were the same age when administered. Some tests were administered within 30 minutes after reconstitution of the tablet with the paired arm receiving considerably older antigen — still no significant differences were observed. Based on these results, we were satisfied that a single tuberculin skin test with 5 TU of tableted PPD tuberculin could serve as an adequate baseline from which to detect future conversion to the same antigen.

The Division of Biological Standards, National Institutes of Health, U. S. Public Health Service, recently has directed that tableted PPD must be administered within 30 minutes after reconstitution.<sup>3</sup> This places obvious significant limitations on its practical usefulness. Plans apparently are being made to replace the tableted form of PPD tuberculin in the near future with a liquid stabilized PPD which will be bioequivalent to

## The Author

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5 TU of PPD-S in phosphate buffer (without Tween) as demonstrated in humans.

The comparison of 5 TU of tableted PPD with 5 TU of Tween-80 stabilized PPD in this study clearly demonstrates a significant difference in response to these two antigens. If the employees tested with tableted PPD only in the first series were later tested with the stabilized PPD and the same differences observed in the second series were seen, there would have been 42 persons (5.6 percent of 745 with reactions < 9 mm) falsely considered as converters. This is compared to a tuberculin conversion rate in 1971 of approximately 1 percent in employees of the Cincinnati General Hospital. The tuberculin conversion rate in the Veterans Administration hospitals has been reported as 2.3 percent,<sup>4</sup> and at the University of Virginia Hospital as 1.9 percent.<sup>5</sup>

Of 287 nonstabilized tuberculin negative employees, Zack<sup>6</sup> found 12 who "converted" from a negative nonstabilized to a positive stabilized test without clinical evidence of tuberculosis. Other investigators<sup>7,8</sup> have reported large differences between simultaneously administered tuberculin in patients known to have tuberculosis.

It is evident that, for a number of possible reasons presently available, PPD tuberculin are not adequately standardized products permitting one to accurately compare results obtained with one product to the same dose of another. Regardless of what future standardized PPD tuberculin becomes available, one should exercise caution in using negative or questionably positive results obtained from the tableted PPD as a baseline against which to judge recent conversion when using other antigens. Until more information is available, it may be prudent to base conversion only on a change from negative to positive to the same test antigen material. Only in this way can the needless concern and unnecessary potential risk of isoniazid prophylaxis in persons falsely diagnosed as tuberculin converters be avoided.

### Summary

Two tuberculin skin tests were administered simultaneously to hospital employees as part of a

routine tuberculosis surveillance program. In the first series, 790 employees received 5 tuberculin units (5 TU) of reconstituted tableted PPD tuberculin in both arms. A second series of 429 employees received 5 TU of tableted PPD tuberculin in one arm and 5 TU of a Tween-80 stabilized PPD tuberculin in the other. No significant differences were observed in the first series; however, in the second series, 5.6 percent of the employees had a significant positive difference to the stabilized PPD.

Caution is urged when diagnosing conversion based on reactions to the same dose of different skin test antigens, since there are significant variations in response, despite the labeled biological equivalence.

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# E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

A 38-year-old woman, after an extended abdominal operation, complains of hoarseness and a feeling of "something" in her throat. Indirect laryngoscopy reveals lesions on both arytenoid cartilages (Fig. 1). What is the most likely diagnosis, and what therapy should be instituted?

(See p. 376 of this issue for further information and discussion.)

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Submitted February 22, 1973.



FIG. 1. These lesions were noted in patient's larynx after endotracheal intubation.

# Tuberculosis Drug Therapy

## A Review

JOHN H. ACKERMAN, M.D., M.P.H., and JOHN M. D. MORSE, M.D.

WITH THE present armamentarium of antituberculosis drugs, success in drug therapy of tuberculosis should not only be anticipated but demanded. With the proper selection of drugs, 95 percent or more patients completely eliminate tubercle bacilli from their sputum within the first six months of therapy.<sup>1</sup>

Development of drug-resistant tubercle bacilli can greatly complicate the treatment. For this reason, before beginning tuberculosis therapy each physician should clearly have in mind a rational treatment plan.

### Role of Hospitalization

In the past, hospitalization was considered mandatory for all patients with tuberculosis, mainly to isolate them and prevent spread of infection. Clinical and experimental evidence now indicates that once a person is diagnosed and placed on proper drug therapy, he soon becomes markedly less able to transmit his infection. Prolonged isolation is therefore unnecessary.<sup>2,3</sup> It is now possible to treat many people entirely as outpatients.

Hospitalization, preferably in general hospitals, should be considered for: (1) patients who are debilitated from tuberculosis or other concurrent illness; (2) patients for whom an acceptable ambulatory treatment plan cannot be immediately devised; and (3) patients who need retreatment chemotherapy and who need close observation for possible toxic effects of "second-line" drugs.

### Drug Therapy in Initial Treatment of Tuberculosis

In order to make drug therapy successful, it is important to make it easy for the patient. For example, isoniazid can be obtained in 300 mg-tablets. The patient needs to take only one tablet a day, which gives just as good a therapeutic effect as does a 100-mg tablet taken three times a day. Also, streptomycin is generally not required for the treatment of noncavitary pulmonary tuberculosis;

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this eliminates the need for painful injections and worrisome side-effects.

The "first-line" drugs are those which are used in the initial treatment of any case of active tuberculosis. They are effective and have relatively few side-effects. (See Table 1 and Figure 1.) These drugs are: isoniazid, ethambutol, streptomycin, and, in children, para-aminosalicylic acid (PAS). Rifampin is now under consideration as a "first-line" drug, as will be discussed later.

For all cases of active tuberculosis, a minimum of two drugs is recommended. Use of a single drug may result in the emergence of drug-resistant tubercle bacilli.<sup>4</sup> Whether a two- or a three-drug regimen is used depends upon the estimated size of the bacterial population.

In noncavitary pulmonary tuberculosis and many cases of extrapulmonary tuberculosis, the bacterial population is relatively small,<sup>5</sup> and the chance of a resistant organism emerging when two drugs are used is slight. In adults, the *isoniazid-ethambutol* combination has proved to be highly effective. Lees, et al<sup>6</sup> found that this regimen produced bacteriologic reversal of infectiousness in 98 percent of their patients within the first six months of therapy. Only 1 of 115 patients failed to complete therapy owing to side-effects.

In *cavitary tuberculosis* the bacterial population is large. The classic triple-drug regimen of isoniazid, ethambutol, and streptomycin is highly



effective. Streptomycin should be continued until the bacterial population has been reduced, as reflected by sputum-smear examinations, then two-drug therapy with isoniazid-ethambutol can be maintained for the duration of therapy. Excellent results have also been obtained by the use of rifampin in patients with far-advanced cavitary tuberculosis (as will be discussed later).

### “First-Line” Drugs

The “first-line” drugs are as follows:

*Isoniazid.* The usual adult dose is 300 mg once a day. Isoniazid should be included in every drug regimen if no contraindication, such as liver disease, is present.<sup>7</sup> Pyridoxine should be added, in order to prevent peripheral neuritis, if the person has preexisting neurologic disease or is receiving more than 5 mg/kg/day.

*Ethambutol.* The adult dose is 15 mg/kg/day given once a day. Ethambutol has replaced para-aminosalicylic acid (PAS) as a “first-line” drug for use in adults. It is very effective, has few side effects, and optic neuritis is rare when this dose is used. Ethambutol has not been approved for use in children.

*Streptomycin.* To obtain the maximum benefit from streptomycin, it is necessary to administer it on a daily basis for 60 to 90 days. If necessary after this period, it can be given two or three times weekly for two to four months. The usual adult daily dose is 15 mg/kg/day which for the average size adult is 1.0 gm given intramuscularly. All patients should be observed for the development of vestibular toxicity as manifested by vertigo, dizziness, and nausea, all of which are more common in

older patients. Streptomycin is excreted almost entirely by the kidney and should not be given to patients with renal failure. Dihydrostreptomycin is not in clinical use today due to its tendency to produce severe hearing loss.

*PAS.* In adults, it is rarely necessary to use para-aminosalicylic acid (PAS) since ethambutol is much better tolerated. Approximately 30 to 40 percent of all patients have to discontinue its use owing to the unpleasant side-effects.<sup>8</sup> Children tolerate PAS better than adults, and the INH-PAS regimen is recommended in favor of INH-streptomycin for use in children.

*Rifampin.* The usual adult dose is 600 mg per day. This is the newest antituberculosis drug and appears to be equally as effective as isoniazid. At the present time, there is some question about the place of rifampin in current therapy.<sup>9</sup>

The place of rifampin in the *retreatment* of patients who have relapsed after a course of therapy with other drugs is clear; rifampin has been demonstrated to be highly effective.<sup>10,11</sup>

However, the role of rifampin in the *initial* treatment of tuberculosis is less certain; there are arguments for and against its use as a “first-line” drug. Studies have shown that the isoniazid-rifampin regimen in initial treatment of far-advanced cavitary disease is as effective as the standard triple-drug regimen of isoniazid, ethambutol, and streptomycin and that it is much more acceptable from the patient’s point of view.<sup>12-14</sup>

Arguments against the use of rifampin in initial treatment center around the cost, which is approximately \$600 per year. Also, there has not

TABLE 1. Frequently Used Antituberculosis Drugs<sup>17</sup>

| Drug  | Dose  | Toxic Effects  | Allergic Manifestations   | Precautions  |
|---|---|--|---|--|
| Isoniazid (INH)   | Adults—3-5mg/kg/day<br>Usually 300 mg/day<br>Children—10-20 mg/kg/day<br>not over 400 mg/day            | Peripheral neuritis (0.3%)   | Incidence 0.1%<br>Hepatitis<br>Fever<br>Skin rash                 | Pyridoxine 50 mg/day for preexisting neurologic disease, malnourished patients, or those receiving greater than 5 mg/kg day. Monthly visits to check for hepatic toxicity. |
| Ethambutol  | 15 mg/kg/day  | Rare—retrobulbar neuritis with reduced visual acuity, scotomas   | Skin rash   | Base-line visual acuity test and repeat test if patient complains of changes in vision.  |
| Streptomycin  | Adults—15 mg/kg/day<br>Usually 1 gm/day for 60-90 days<br>Children—20-40 mg/kg/day<br>Not over 1 gm/day | Vestibular dysfunction as manifested by vertigo, dizziness, nausea (10-15%)<br>Auditory disturbances—tinnitus and high-tone loss.<br>Perioral paresthesias | Incidence 5.8%<br>Skin rash<br>Fever (rare)                       | Observation for signs of vestibular and auditory dysfunction.  |
| Rifampin  | Usually 600 mg/day  | Hepatitis (rare)   | When taken intermittently:<br>Fever<br>Nausea<br>Thrombocytopenia | Advise patient to take continuously.   |
| PAS - C<br>(para-amino salicylic acid with ascorbic acid) | Children—150 mg/kg/day<br>in two divided doses  | GI irritation (10-20%)   | Incidence 7%<br>Fever<br>Skin rash<br>Hepatitis (0.2%)<br>Myalgia | Give with meals. May start with small dose and gradually increase to adequate levels.  |

been a sufficient amount of time to determine the necessary duration of therapy.

If rifampin is to be used in initial treatment, the following guidelines<sup>14</sup> should be used:

(1) The isoniazid-rifampin regimen is recommended for use only in cavitary disease. The less expensive isoniazid-ethambutol regimen should be used for noncavitary cases.

(2) No increase in effectiveness can be obtained by the addition of ethambutol (and probably any other drug) to this isoniazid-rifampin regimen.

(3) Ninety-five percent of all patients treated for far-advanced cavitary tuberculosis with isoniazid-rifampin are culture-negative at six months. Therefore, it may be possible to use isoniazid-rifampin for the first four to six months of therapy and then switch to the less expensive regimen of isoniazid-ethambutol for the completion of therapy.

### Drug Susceptibility Tests

The interpretation of these tests must be conservative.<sup>15</sup> Most important is the patient's response to therapy. If the patient is doing well, the finding of drug resistance should not precipitate a sudden change of regimen.

If the patient has a poor response to initial drug therapy (failure to convert bacteriologically within six months), or if there is a history of previous drug treatment, then a laboratory documentation of drug resistance should be taken into consideration in planning a new drug regimen.

Poor response also may be caused by poor drug intake.

### Therapy of Initial Treatment Failures

Patients are classified as initial treatment failures if they fail to convert their sputum within the first six months of therapy or if they have a reactivation of disease after completion of drug therapy in the past.

These patients require close examination of their drug intake as well as susceptibility tests on sputum. If new drugs need to be introduced, at least two drugs to which the patient's organisms are sensitive must be used.

The combination of ethambutol-rifampin for retreatment cases has been shown to be highly effective.<sup>10</sup> Davidson et al,<sup>11</sup> give a good discussion of this topic.

Now that rifampin has been introduced, the other "second-line" drugs rarely need to be used. These include cycloserine, ethionamide, capreomycin, and kanamycin.

### Duration of Chemotherapy

Eighteen to 24 months of multiple drug therapy is sufficient.<sup>4</sup>

### Follow-Up of Patients after Completion of Chemotherapy

Patients who have successfully completed 18 to 24 months of chemotherapy can be dismissed from follow-up. They should be instructed to seek medical attention if a cough or other pulmonary

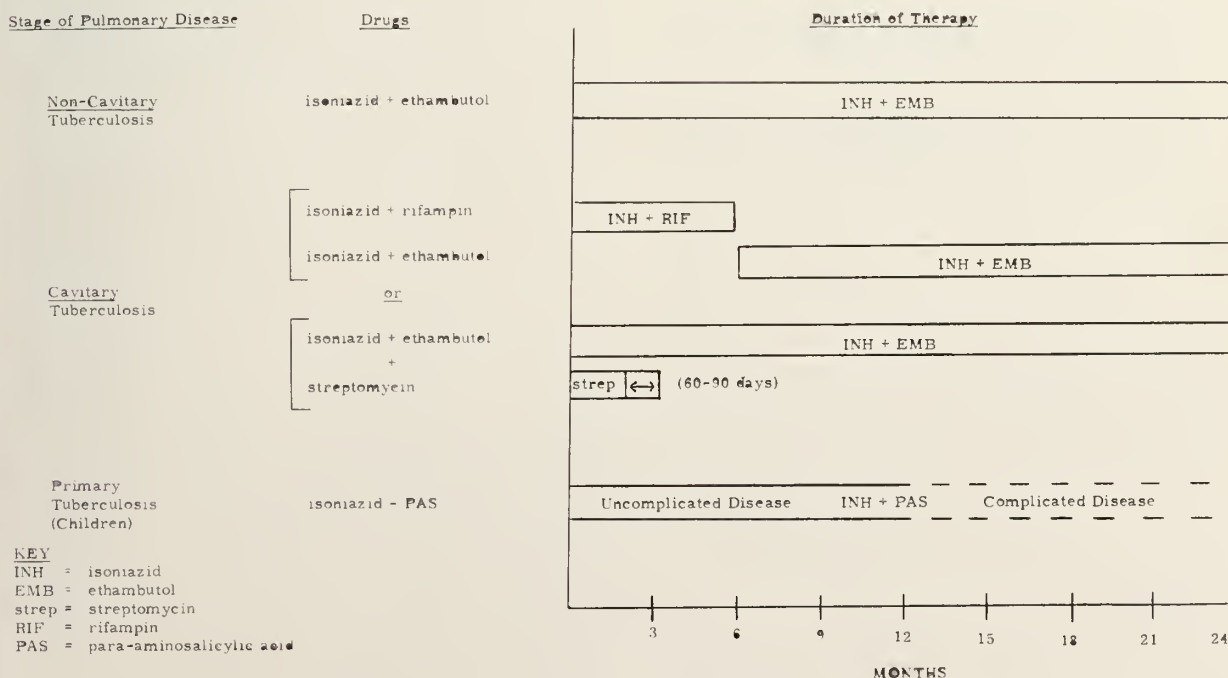


FIG. 1. Schedule for treatment of active pulmonary tuberculosis.

symptoms occur and persist for more than seven to ten days.

### Chemoprophylaxis

**Contacts:** A contact is a person who has been repeatedly exposed to the air from a person with infectious tuberculosis. Household members, especially children, are the ones most likely to become infected. Numerous clinical trials have shown that one year of isoniazid therapy can prevent the development of active disease.<sup>16</sup>

Many tuberculosis registers are overburdened with people who return for yearly examinations and x-rays. Many of these people—"old" TB patients, reactors with fibrosis shown on roentgenograms, reactors with normal roentgenograms — never receive isoniazid. Clinical studies have shown that the present administration of one year of isoniazid to these people can greatly reduce their chance of developing active disease in the future.<sup>16</sup> They should be identified in the register, treated, then dismissed completely from follow-up.

### Summary

Tuberculosis drug therapy for initial treatment is relatively straightforward. Patients with *noncavitary* tuberculosis respond well to double therapy with isoniazid-ethambutol. Those with *cavitary* tuberculosis require either triple therapy with isoniazid, ethambutol, and streptomycin or a course of isoniazid-rifampin.

Once it has been established that the person has completed 18 to 24 months of continuous therapy and has remained inactive, no further follow-up is necessary.

### Generic and Trade Names of Drugs

Rifampin—Rifadin (Dow Chemical Co.)

Rifampin—Rimactane (CIBA Pharmaceutical Co.)

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# Public Information and Heart Attack

## Report of an Educational Program

LOUIS A. BLACK, M.D., AND DONALD D. BROWN, PH.D.

THE PROBLEM OF THE PREHOSPITAL phase of the patient with acute myocardial infarction has emerged as an important challenge to the health profession.<sup>1-4</sup> A great deal of attention has been given to patients dying suddenly, and often unexpectedly, with heart attacks since research first indicated that some 60 percent of this rather large group did not survive to reach the

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*See Guest Editorial on p. 385*

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hospital.<sup>5-7</sup> On the basis of data accumulated from the early coronary care ambulance systems, it seems logical to assume that the great majority of early deaths are due to ventricular fibrillation and are probably preventable and/or treatable if the patient can reach care in time.<sup>4,8-10</sup>

The matter of reducing the time it takes to get the heart attack victim to care begins with making the potential patient aware of the need for help early. It may be influenced by the mode of entry into the care system, eg, whether through the private physician, an emergency ambulance system, or the emergency room itself.<sup>11</sup> It certainly involves the method and time of transportation to the hospital and the time getting from the hospital triage area to the protection of the monitoring system.<sup>12-14</sup>

Of all the increments in time mentioned, the time it takes the patient to recognize he is in trouble seems to be the most important and the longest. There is general agreement that unless this period is reduced substantially a major reduction in heart attack death rate cannot occur.<sup>9,13,15,16</sup> The number of these early deaths which occur without any warning is uncertain, but Kuller's studies indicate that many patients

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who die "suddenly" have had some symptoms which have been misinterpreted during the hours, days, or even weeks preceding the death.<sup>7</sup>

Factors influencing patient delay have been studied by Hackett and Cassem and others.<sup>11,14,17</sup> These factors include: (1) awareness of symptoms, (2) interpretation of significance, and (3) psychiatric denial of symptoms' significance. Various investigations have suggested that a public education program on symptoms' significance might be effective in reducing delay-time.<sup>4,13,18</sup>

The purpose of our study was to see if an intensive educational project conducted for one year in a localized area could affect any significant change in the knowledge and behavior of a patient threatened with symptoms of myocardial infarction.

### **Background and Methods**

Hardin County has a stable population of 30,000. It is served by a single hospital operating a combined coronary care-intensive care unit since May 1966. The incidence of documented myocardial infarctions annually had been remarkably

stable (64 to 66 per year). Various data including delay time had been kept since March 1969.

Myocardial infarction was defined as having occurred when significant Q waves appeared in the electrocardiogram (ECG) following an attack accompanied by characteristic rise and fall in creatine phosphokinase (CPK), serum glutamic oxaloacetic transaminase (SGOT), and lactic dehydrogenase (LDH) values. It was also so designated when characteristic evolutionary ST-T changes occurred in the *absence* of Q waves only when clear-cut history and enzyme changes occurred. All "possible" myocardial infarctions without these changes were excluded. Time between onset of clinical myocardial infarction and entrance into the coronary care unit was recorded by the attending physician, and by admitting coronary care unit nurses, and the time intervals were reviewed separately by the coronary care nurse director and the physician director. When any uncertainty arose as to time of onset of myocardial infarction in the patients with prodromes, the pattern of rise and fall of the three enzymes was used to determine whether infarction had occurred with certainty at the time suggested. In the event the enzyme pattern was not helpful, the longer period was chosen.

In early 1970, the local branch of the American Heart Association developed a committee of lay and professional people to plan and undertake a project in public information on early warning signs. Methods of evaluation were formulated. It was decided, after researching previous community education projects, that nothing short of massive speaker-audience encounters would dramatize the information presented. Unique methods of reaching all types of audiences were developed. A 13-member Speakers' Bureau of physicians and nurses undertook to deliver the heart message: "What *are* significant symptoms?" and "What do you do if you are in Hardin County and these symptoms appear?" It seemed important to suggest that if in doubt about the significance of symptoms, a potential patient should describe the symptoms and ask advice of a family member, a friend, or co-worker. Hackett and Cassem had found that even patients who denied having symptoms received care earlier or later depending on the advice of others.<sup>11</sup>

Additional and important aspects of the Heart Year project were exercise programs, diet seminars, and school projects. All of these not only were designed to be important in themselves, but also to focus more local attention and enthusiasm on the basic project.

### Evaluation

1. During the summer of 1970, a public survey was planned with a post-test to be given again

at the end of the year. Methods, specific questions, and methods of randomizing this study in the county were discussed with representatives of the American Heart Association (Fig. 1).

2. The total number of patients reaching the coronary care unit in the year following this campaign was considered to be a second method of determining effectiveness, since this was a stable community as far as population movement was concerned and since a remarkably stable number of myocardial infarctions were documented annually in the five years preceding the study. It seemed reasonable to assume that if the information program was successful, a larger number of documented patients with myocardial infarction would appear.

3. Studies on delay-time for 17 months prior to the beginning of the project were compared with studies on delay-time in the year following the onset of the public information project.

### Results

1. During the year following the information project, there was an increase of public awareness of symptoms' significance varying between 16 percent and 20 percent (Table 1). Other aspects of public information changed to a lesser degree, such as "What to do in Hardin County." We attributed this to the type of question and to the fact that this small community was fairly well informed about responding to an attack even before the informational project.

2. There was an increase of 17 percent in the total number of myocardial infarctions admitted to the coronary care unit during the year after the project was started (Table 2).

3. The number of patients reaching the coronary care unit within the first hour after heart attack *increased* 111 percent. There was an increase of 64 percent of patients arriving within two hours, and 62 percent of the patients were in the unit within four hours from symptom onset, an increase of 40 percent over the preproject-documented, 18-month period (Table 3).

4. A significant number of patients with diagnoses of coronary insufficiency, possible heart attack, and impending myocardial infarction came to care for reasons related to the heart information program and were not included in the study data.

5. The hospital mortality rate for heart attack during the year-long project was 28 percent. This compared with a mortality rate of 12.6 percent during the 18 months before the project start (see Table 4), and a five-year average of 16.5 percent mortality—the entire experience of our unit prior to the period of September 1970 to August 31, 1971. Comparative Peel indices (Tables 4 and 5) indicate that we met with a higher percentage of severe problems during the latter period. None of

# HARDIN COUNTY HEART EDUCATION SURVEY

1. Age:           (    ) Under 25   (    ) 25-44           (    ) 45-64           (    ) 65 or over
2. Sex:           (    ) Male                           (    ) Female
3. Residence:    (    ) Urban                           (    ) Rural
4. Which of the following causes the most deaths each year in the U.S.?
 

|                      |                   |
|----------------------|-------------------|
| (    ) Cancer        | (    ) Diabetes   |
| (    ) Accidents     | (    ) Influenza  |
| (    ) Heart Disease | (    ) Don't know |
5. Are men more likely to have heart attacks than women?
 

|            |           |                   |
|------------|-----------|-------------------|
| (    ) Yes | (    ) No | (    ) Don't know |
|------------|-----------|-------------------|
6. Do heart attacks occur more frequently in young adults today than they did 20 years ago?
 

|            |           |                   |
|------------|-----------|-------------------|
| (    ) Yes | (    ) No | (    ) Don't know |
|------------|-----------|-------------------|
7. Check the items which you think increase one's chance of having a heart attack. (Check all that apply.)
 

|                                |  |
|--------------------------------|--|
| (    ) Smoking cigarettes      | (    ) Diabetes                        |
| (    ) High blood pressure     | (    ) Overweight                      |
| (    ) High cholesterol levels | (    ) Regular heavy physical activity |
8. Check the items which you believe to be the usual symptoms of a heart attack. (Check all that apply.)
 

|                            |                                     |  |
|----------------------------|-------------------------------------|--|
| (    ) Shortness of breath | (    ) Sharp pain in the left chest | (    ) Prolonged pain behind the breastbone in the center of the chest |
| (    ) Sweating            |                                     |  |
9. Does unconsciousness usually accompany a heart attack?
 

|            |           |                   |
|------------|-----------|-------------------|
| (    ) Yes | (    ) No | (    ) Don't know |
|------------|-----------|-------------------|
10. Does the heart attack patient often get temporary relief with belching?
 

|            |           |                   |
|------------|-----------|-------------------|
| (    ) Yes | (    ) No | (    ) Don't know |
|------------|-----------|-------------------|
11. Should a person having a heart attack at home be moved even though he is having pain?
 

|            |           |                   |
|------------|-----------|-------------------|
| (    ) Yes | (    ) No | (    ) Don't know |
|------------|-----------|-------------------|
12. If your doctor is not available by phone and you are having symptoms suspicious of a heart attack, what would you do?
 

|                                 |                                       |                              |
|---------------------------------|---------------------------------------|------------------------------|
| (    ) Wait and phone him later | (    ) Go to the hospital immediately | (    ) Other - specify _____ |
|---------------------------------|---------------------------------------|------------------------------|

FIG. 1. Sample of questionnaire used in survey.

the five patients who died after reporting a delay-time of less than two hours had heard a "heart speaker" or was aware of the project.

## Discussion

One of the concerns about an intense campaign of the type undertaken was the possibility of creating a public panic reaction to nonspecific

symptoms. This did not occur. For some time prior to the project, the system of care in our community had an automatic provision wherein the patient presenting to the paramedical person, usually a nurse on duty in the emergency room, was immediately transported to the coronary care unit if symptoms suggested the possibility of heart attack.

TABLE 1. Pre- and Post-test Results (to Nearest Whole Number)

| Item | 1970<br>Correct<br>Responses<br>% | 1971<br>Correct<br>Responses<br>% | Change<br>% |
|------|-----------------------------------|-----------------------------------|-------------|
| 4    | 54                                | 50                                | -7          |
| 5    | 89                                | 83                                | -7          |
| 6    | 82                                | 82                                | 0           |
| 7    | 65                                | 68                                | +5          |
| 8    | 39                                | 47                                | +20         |
| 9    | 59                                | 62                                | +5          |
| 10   | 30                                | 35                                | +17         |
| 11   | 46                                | 59                                | +28         |
| 12   | 89                                | 90                                | +1          |

TABLE 2. No. of Documented and Possible Myocardial Infarctions Entering the Coronary Care Unit, Pre- and Post-program Start

|            | 4/1/69<br>to<br>8/31/70 | 9/1/70<br>to<br>8/31/71 | %<br>Change<br>Monthly |
|------------|-------------------------|-------------------------|------------------------|
| Documented | 95                      | 75                      | +17                    |
| Possible   | 207                     | 210                     | +60                    |

TABLE 3. Patients Reaching the Coronary Care Unit from Onset of Symptoms, Pre- and Post-program Start

|            | 4/1/69<br>to<br>8/31/70 | 9/1/70<br>to<br>8/31/71 | %<br>Change |
|------------|-------------------------|-------------------------|-------------|
| Under 1 hr | 8.2                     | 17.                     | +111        |
| Under 2 hr | 19.5                    | 32.                     | +64         |
| Under 4 hr | 44.2                    | 62.                     | +40         |



This was done even prior to contacting the attending physician or physician on call.

We saw a specific increase in numbers of these patients admitted with diagnosis of "possible heart attack" during the period. During the 17 months prior to the project, 209 possible myocardial infarctions were admitted and the documented number of those with myocardial infarction was 95. In the 12 months after the project onset, 210 patients with possible myocardial infarctions were admitted or seen in the coronary care unit. Of these, 75 proved to have myocardial infarction. We felt this did represent an increased awareness both on the part of the public and on the part of the people attending in the emergency room, but we felt it fell far short of a panic reaction.

We were disturbed by our high mortality rate during the project year studied. During that year, 51.2 percent of our patients with severe heart attacks (Peel Index over 14) died, as compared with 26.8 percent during the previous 17 months. In addition, there were relatively larger numbers of high Peel Index scores (35 cases with a Peel Index over 14) in the last 12 months versus 41 cases during the preceding 17 months. Table 6 roughly compares our experience in both time periods to that reported by Peel and co-workers in 1962 and by Lown, et al in 1967.<sup>17,18</sup> Although we cannot compare exactly our Peel Indices of 20 to 28 with their indices of 17 to 28, it is obvious that our experience of 83 percent mortality during the second time period was devastating to our overall mortality figures.

Many of these patients were old-timers to our coronary care unit with two to four previous myo-

cardial infarctions and chronic congestive failure antedating their terminal illness. Most of these patients died from severe power failure and terminal, profound, cardiovascular collapse.

We concluded we were mainly harvesting end-state deaths from our previous lower mortality years. Of interest to this project was the fact that none of the deaths occurring in the group of patients entering with low delay-time occurred in patients coming to the unit because they had heard a "heart speaker." On the other hand, ten documented instances of early entry because of information from the project derived by the patient, family, or friend were accompanied by only one death.

Nearly everyone interested in precoronary care has concluded that public education is an important, if not the most important, aspect of reduction in patient delay-time, but to our knowledge no other study has attempted to determine if an intense, direct-encounter, public information project will change the behavior pattern of the patient threatened with a serious medical problem. Since the average patient served by the hospital in Hardin County is within 20 minutes of protective care, it seemed obvious to us that the ability of the public to recognize and to act upon the symptoms of an impending myocardial infarction was critical.

During our planning period, a decision was made at the American Heart Association level to emphasize early warning signs and subsequently, in February 1971, a national informational program was carried out. We had reason to believe that this type of informational campaign, conducted largely by television, radio, and press coverage,

TABLE 4. Comparative Peel Index (P.I.), Deaths (D), and Delay-Time, Pre- and Post-program Start

| Duration of Symptoms in Hours   | P.I. (-5) | D | P.I. (5-9) | D | P.I. (10-14) | D | P.I. (15-19) | D | P.I. (20-28) | D  |
|---------------------------------|-----------|---|------------|---|--------------|---|--------------|---|--------------|----|
| 4/1/69 Through 3/31/70 (N = 95) |           |   |            |   |              |   |              |   |              |    |
| 0 - 1                           | 0         | 0 | 2          | 0 | 4            | 0 | 2            | 0 | 2            | 2  |
| 1 - 2                           | 0         | 0 | 6          | 0 | 5            | 0 | 2            | 0 | 3            | 1  |
| 2 - 4                           | 1         | 0 | 4          | 0 | 4            | 0 | 7            | 0 | 5            | 1  |
| 4 - 8                           | 0         | 0 | 3          | 0 | 2            | 0 | 5            | 1 | 1            | 1  |
| 8 - 12                          | 0         | 0 | 2          | 0 | 1            | 0 | 3            | 0 | 3            | 3  |
| 12 - 24                         | 0         | 0 | 2          | 0 | 3            | 0 | 1            | 0 | 2            | 1  |
| Over 24                         | 2         | 0 | 6          | 0 | 7            | 1 | 3            | 0 | 2            | 0  |
| Total                           | 3         | 0 | 25         | 0 | 26           | 1 | 23           | 1 | 18           | 9  |
| 9/1/70 Through 8/31/71 (N = 75) |           |   |            |   |              |   |              |   |              |    |
| 0 - 1                           | 0         | 0 | 0          | 0 | 7            | 1 | 3            | 0 | 3            | 3  |
| 1 - 2                           | 0         | 0 | 2          | 0 | 4            | 0 | 2            | 0 | 3            | 1  |
| 2 - 4                           | 0         | 0 | 3          | 0 | 9            | 1 | 7            | 0 | 4            | 4  |
| 4 - 8                           | 0         | 0 | 1          | 0 | 2            | 0 | 0            | 0 | 1            | 1  |
| 8 - 12                          | 0         | 0 | 0          | 0 | 1            | 0 | 0            | 0 | 3            | 3  |
| 12 - 24                         | 0         | 0 | 2          | 0 | 2            | 0 | 2            | 1 | 1            | 1  |
| Over 24                         | 0         | 0 | 1          | 0 | 6            | 1 | 3            | 2 | 3            | 2  |
| Total                           | 0         | 0 | 9          | 0 | 31           | 3 | 17           | 3 | 18           | 15 |

TABLE 5. Coronary Prognostic Index of Peel and Co-workers

|   | Index Score | Patient's Score |
|---|-------------|-----------------|
| <b>Sex and Age</b>  |             |                 |
| Male 54 or less   | 0           |                 |
| 55-59   | 1           |                 |
| 60-64   | 2           |                 |
| 65 or over  | 3           |                 |
| Female 64 or less   | 2           |                 |
| 65 or over  | 3           |                 |
| <b>Previous History</b>   |             |                 |
| No cardiovascular disease   | 0           |                 |
| Angina pectoris   | 1           |                 |
| Other cardiovascular disease or exertional dyspnea  | 3           |                 |
| Previous infarction   | 6           |                 |
| <b>Shock</b>  |             |                 |
| Absent  | 0           |                 |
| Mild, transient at onset  | 1           |                 |
| Moderate, present at onset but subsiding with rest and sedation   | 5           |                 |
| Severe, persisting despite rest and sedation  | 7           |                 |
| <b>Heart Failure</b>  |             |                 |
| Absent  | 0           |                 |
| Few basal rales only  | 1           |                 |
| Any one of the following: breathlessness, edema, acute pulmonary edema, orthopnea, gallop rhythm, liver congestion, increased venous pressure | 4           |                 |
| <b>Electrocardiogram</b>  |             |                 |
| Normal QRS, ST-T changes  | 1           |                 |
| QR complex  | 3           |                 |
| QS complex or BBB   | 4           |                 |
| <b>Rhythm</b>   |             |                 |
| Sinus   | 0           |                 |
| Any of following: atrial flutter, fibrillation, ventricular tachycardia, frequent VPB's, modal rhythm, or heart block                         | 4           |                 |

would not drastically change the behavior of a patient when presented with his own threatening symptoms. The Piedmont Study showed that a well-coordinated traditional campaign on various heart subjects, carried out for a year, failed to change the knowledge of those subjects by the public.<sup>19</sup>

Other studies indicate that the personal approach is more effective in promoting awareness and behavioral change than is mass communication. Klapper, in summing up the results of several research projects, states: "Personal influence appears to exercise a more crucial influence toward change than does mass communication when both such influences are present."<sup>20</sup> The mass media depends primarily on the *content* of their communications, while in personal communications the source is as important as the content itself.<sup>21</sup> People can induce each other to a wide

variety of activities as a result of their interpersonal relations and their influence goes far beyond the content of their communications.<sup>22</sup> Thus it would seem that, because of their status in a small community, physicians and other health professionals can be a major factor in effecting cognitive and behavioral change.

We concluded that direct encounter between public information speakers and the public, *reinforced* by traditional methods of publicity and special projects, would have a far greater impact than the mass communication methods so often used by voluntary health agencies. We also felt that the groups usually reached by public information speakers were largely female and they were more aware than the general community. The results of our pre-test, which were broken down by age and sex, support this assumption. In our projects, an attempt was made to reach *all* potential heart attack victims, their families, friends, and co-workers. This required scheduling speakers into industrial plants, into churches (sometimes as a substitute for the Sunday sermon), and into all manner of nontraditional groups. In Hardin County during 1970 and 1971, it was rare indeed for an organization not to have a heart speaker, either as a main program or as a preprogram personal communication.

A considerable amount of public interest was developed as a result of this aggressive approach on the part of the health professionals, and the public contact was used to discuss other health concerns of the local population during the question-and-answer period.

Previous studies had suggested that in communities with mobile coronary-care ambulance systems there seemed to have been an impact on public awareness of how and when to act when confronted with the symptoms of a heart attack.<sup>13,23,24</sup> Various authorities have considered the educational impact of these projects a major factor in their success.<sup>9,14</sup> If so, then the average community not yet capable of developing a modified coronary-care ambulance system might well consider the low-cost (but substantial) benefit that seems to have resulted from the project described.

Considering our observations, it seems logical to conclude that:

1. A significant reduction in delay-time between the onset of myocardial infarction and entrance into the coronary care unit can be effected by an intense public informational campaign.
2. The extremely low cost of such a campaign, plus the additional benefits which accrue to the health professionals involved in the project, may well be a practical approach to further lowering the death rate from heart attack in the smaller

TABLE 6. Comparative Peel Index Distribution and Mortality between Peel and Co-workers,<sup>17</sup> Lown, et al,<sup>18</sup> and Hardin Memorial Hospital

| Peel Index | Peel and Co-workers |             | Lown, et al  |             | Hardin Memorial Hospital 1969-1970 |              |             | Hardin Memorial Hospital 1970-1971 |             |
|------------|---------------------|-------------|--------------|-------------|------------------------------------|--------------|-------------|------------------------------------|-------------|
|            | Distribution        | Mortality % | Distribution | Mortality % | Peel Index                         | Distribution | Mortality % | Distribution                       | Mortality % |
| 1 - 8      | 32.2                | 2.5         | 22.1         | 1.6         | 1 - 9                              | 29.4         | 0           | 11.2                               | 0           |
| 9 - 12     | 28.0                | 12.5        | 26.2         | 10.5        | 10 - 14                            | 27.3         | 3.8         | 41.1                               | 9.6         |
| 13 - 16    | 22.4                | 23.4        | 25.5         | 14.8        | 15 - 19                            | 24.4         | 4.3         | 22.4                               | 17.5        |
| 17 - 28    | 17.4                | 64.1        | 26.2         | 42.1        | 20 - 28                            | 18.9         | 55.0        | 25.2                               | 83.3        |

community with or without a coronary care ambulance system.

3. The traditional methods of disseminating heart information probably will not be a substitute for a direct project of personal encounters between the health professionals and the public.

### Summary

A county with a stable population of 30,000 was the setting for an intense one-year program designed to reduce patient-decision time by educating the public to recognize and act upon the symptoms of an impending myocardial infarction. Personal encounters between health professionals and the general population was the main vehicle used in an attempt to effect both cognitive and behavioral change.

A pre- and post-project survey indicated an increased public awareness of the symptoms of an impending heart attack. There was also an increase in the number of possible myocardial infarctions admitted or seen in the coronary care unit, but we felt it fell far short of a panic reaction. In the 12-month period following the project start, there was a significant reduction in delay-time between the onset of myocardial infarction and entrance into the coronary care unit.

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## Postoperative Psychosis

HENRY GOLDHIRSCH, M.D., Cleveland, Ohio

THE SCOPE of surgical procedures has enlarged tremendously during the past 25 years. Whereas at the end of World War II an intrathoracic procedure was a rather uncommon occurrence, the thoracic and vascular surgeon today replaces major vessels, by-passes coronary arteries, introduces artificial heart valves, yes, even replaces whole hearts. Urologists replace kidneys, orthopedists introduce artificial joints, and on and on.

Suffice it to say that the surgeon has become rather aggressive, and certainly, the majority of patients involved benefit physically from the indicated procedures. Surgical intensive care units have been built in most major hospitals to care for the patients during the immediate postoperative period. Many of these units are right out of science fiction magazines of 25 years ago, in terms of the apparatus, tubes, machines, etc. available. All, to be sure, are to help the physical survival of the patient. In these units, as much sterility as feasible is kept; visitors are usually allowed for two 15-minute periods during the day; and the staff is very busy, short-handed, often hurrying from one emergency situation to another.

Unfortunately, the bodies lying there in these units not only have their individual surgical and physical problems and emergencies, but they also have their emotional and psychologic reactions and crises. Unfortunately, these bodies have brains attached to them, that can feel, that can fear, that can suspect the worst, and deny at the same time

its occurrence. The patients are scared to DEATH. They are, as a rule, treated with narcotics and analgesics, in a sort of twilight and psychologic isolation. Many things are done to them and for them by changing shifts of doctors and nurses, which help to increase the estrangement. For gone are the days when nursing members of religious orders would spend their every day and night at the bedside of their patient until the danger had passed.

During the past several weeks, I have had a number of occasions to consult with such patients. It has been these recent opportunities which have made me feel compelled to ventilate some of my feelings, concerns, and experiences.

Whereas most of us are extremely active, or should be, in "preparing" a *child* for a hospital or surgical experience, it is generally accepted procedure to let the *adult* fend for himself. Concerned parents, pediatricians, and those in the mental health fields will go to no end to explain "all" to the child, anticipate his every feeling and concern, interpret his fear of being cut open, not waking up from anesthesia, being abandoned, and other fears. The adult going in for a repair of an aortic aneurysm, or coronary by-pass is often told that though a major procedure, it's no more than "a gallbladder." "You should be up and about the next day" . . . The patient is afraid of dying—the surgeon speaks of survival. The patient fears his total impotence and general helplessness — the surgeon speaks of his walking about the next day. How can a surgeon face with his patient prior to surgery the possibility—sometimes the probability—of death? Let's face it . . . that just is not the stuff most surgeons are made of!! Furthermore, it would not necessarily be in the best interest of the surgeon-patient relationship.

It is an extremely frustrating experience for a psychiatrist to be called in consultation two or three days after surgery, for a patient who is flagrantly

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From time to time, we shall publish essays expressing personal opinions on clinical and scientific subjects. It is to be understood that these represent the authors' personal opinions, not necessarily representing or contradicting those of *The Journal* or the Association. Contributions to this feature and letters regarding those published will be welcome, but *The Journal* will reserve the right to reject or to edit both the essays and the responses. — *The Editor*

Submitted December 12, 1972.

psychotic, delusional, paranoid, and often hallucinating, frequently pulling out his intravenous and other tubes, attempting to get out of bed and to leave the hospital. Sometimes, as in one of my recent cases, it has happened ten days after abdominal aneurysm repair, and two days after gastrotomy for gastric bleeding. Gastric hemorrhage after major surgical procedures is on the increase. Allegedly due to the physical stress of the surgery, one may wonder about the part the psyche may play in the etiology. What a problem to attempt to reach this type of patient one has never met before!! At the same time, one needs to deal with the family who cannot "understand" why their loved one suddenly "needs a psychiatrist."

Generally the patient can be reached through diligent interpretation of his fears and concerns which can be deduced from the things he says. There is frequently at least a temporary clearing of the sensorium when the correct feeling or concern is interpreted to the patient. Often a liaison with the patient is quickly established. The patient is extremely grateful to be told that he must be scared to death of all the things that have happened to him. He finally finds some relief to be told that he doesn't have to like all that goes on, and that "were I in your position, I would yell bloody murder." He finally feels that there is someone on his side who identifies with him to help ward off the aggressor and all the aggressions

perpetrated by the well-meaning doctors and nurses. For, after all, how dare a patient not appreciate all that is being done to save his life?

Illness breeds regression, and hospitalization and immobilization for any period of time furthers such regression. Regression implies modes of behaviour, thinking, and feeling reminiscent of earlier years. Somehow the ego's ability to master critical situations diminishes . . . the patient needs a little help.

A "work-up" prior to most elective surgical procedures is accepted operating procedure—intravenous pyelograms, gastrointestinal series, barium enema and others, all the blood work, tests and procedures, often until there are "no more veins" for the anesthesiologist to employ. How about a psychiatric work-up prior to some of our critical surgical procedures? And I *don't* mean psychological testing, psychological profiles, or standardized and sterile evaluations for the production of statistical data. I mean the establishment of a relationship, preferably several weeks prior to surgery, with a psychiatrist who is motivated to do this kind of therapy. The elucidation of whatever concerns, fears, and anxieties; the presence of that psychiatrist before and after surgery may enable a patient to feel that he is joined by a professional in his defense against the tubes and the wires, the pans and the needles, the machines and the masks . . . yes, the doctors and the nurses.

## Discussion of E.N.T. Case of the Month

*(continued from p. 364)*

These lesions have the typical appearance of contact granulomas. These mounds of granulation tissue characteristically appear on the arytenoid cartilages in the posterior aspect of the larynx. They are usually secondary to laryngeal trauma, the most common cause being prolonged endotracheal intubation.

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**Warnings:** Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis. In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

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**Precautions:** Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

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**Adverse Reactions:** Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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# Neurilemmoma of the Vagus Nerve in the Neck

## Case Report and Review of the Literature

STEPHEN M. CATTANEO, M.D.

NEURILEMMOMA of the vagus nerve in the neck is a relatively rare lesion. In 1956, Gore and his associates<sup>1</sup> reviewed a large series of 389 cases of neurilemmoma occurring within the central and peripheral nervous systems. The majority of these tumors arose from the acoustic nerve. Of 138 cases involving the peripheral nerves, 38 percent occurred in the head and neck. Only four neurilemmomas arose in the vagus nerve. Horwich and Hawe,<sup>2</sup> after an extensive review of the literature, found 21 cases involving the vagus nerve, including the four reported by Gore, et al, and added two more cases of their own. Additional single case reports have been described by Ehrlich and Martin,<sup>3</sup> Putney, Moran, and Thomas,<sup>4</sup> Iliades and Watson,<sup>5</sup> and Holland.<sup>6</sup> Reports of two cases by Leichtling, Lesnick, and Garlock<sup>7</sup> and, more recently, by Rosenfeld, Graves, and Lawrence<sup>8</sup> brings this total to 31 cases. An additional case is reported here.

### Case Report

This 19-year old white male was hospitalized on January 19, 1969, with a small, painless left neck mass of which he first became aware two weeks prior to admission. On January 7, he was evaluated in the Medical Clinic at Lockbourne Air Force Base, Columbus, Ohio, for an asymptomatic swelling in the left anterior cervical chain. The possibility of lymphoma prompted admission for biopsy. Admission evaluation revealed a healthy man in no apparent distress. There was no history of paroxysmal cough or dysphagia. His voice was

### *The Author*

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unaltered. On examination, a firm, slightly movable, non-tender mass, approximately 3 cm in size, was palpable in the anterior triangle of the left neck at the upper margin of the sternomastoid muscle. There was some degree of lateral motion but none in the vertical direction. The mass did not move on swallowing.

During the patient's hospital course, he remained afebrile and asymptomatic except for a mild pressure sensation in the neck. The mass was thought to be perceptibly increasing in size. There was no protrusion of the lateral pharyngeal wall on oral examination. Indirect laryngoscopy and nasopharyngoscopy were unremarkable. Preoperative laboratory studies, including soft tissue x-ray films of the neck, were essentially unremarkable. On January 28, surgical exploration was performed through an 8-cm incision parallel to the anterior border of the sternomastoid muscle, beginning 1 cm below the mastoid process. An oblong, encapsulated tumor, 3 X 3.5 cm in size, was found within the carotid sheath, arising from the vagus nerve. The lesion was encompassed by the vagal nerve fibers which were attenuated and splayed over the surface of the capsule. The ma-

jority of the nerve fibers were preserved with extracapsular dissection. The lamellated capsule was adherent at its superior and inferior poles, the points of attachment to the main trunk of the vagus nerve.

Postoperatively, left vocal cord palsy was noted. The patient's voice was deep, raspy, and difficult to control. An intermittent, dry cough developed and gradually subsided. At three months, follow-up evaluation revealed persistent hoarseness with some improvement in the deep, husky character of the voice. A left recurrent laryngeal nerve deficit was demonstrated on indirect laryngoscopy. Function of the cricothyroid appeared to be intact. The left vocal cord was adducted to the midline, and there was tactile sensation to the epiglottis on the left. The patient remained somewhat hoarse for many months, noting that the voice was weak toward the end of the day. Follow-up nine months postoperatively indicated that the voice was forceful. The left vocal cord remained in paramedian position, and there was good compensatory motion of the right vocal cord.

### Pathology

The gross specimen is a firm, rubbery, spherical mass which measures 3 cm in diameter. The cut surface reveals a solid tumor, gray-to-tan in color, glistening and finely trabeculated. It is mottled throughout with small vacuoles filled with pink fluid. The capsule is thick and lamellated near its surface.

Microscopic examination reveals a well-defined fibrous tissue capsule. Within the capsule an occasional nerve filament is seen. The tumor itself is composed predominantly of spindle-shaped cells in parallel array forming bundles and whorls. The prominent palisading of cell nuclei is characteristic of the so-called Antoni type A tissue and pathognomonic of neurilemmoma.<sup>9</sup> In this case, the loose, reticular pattern characteristic of Antoni type B tissue is not a prominent feature, although microcysts filled with eosinophilic fluid are identified.

### Discussion

*Histiogenesis:* Verocay<sup>10,11</sup> first described the histologic features of this lesion in 1908, and in 1910, coined the term "neurinoma." Considerable controversy arose concerning the cell of origin. Several authors<sup>12,13</sup> proposed that the lesion was derived from the fibroblast of the perineurium. In 1932, Masson<sup>9</sup> concurred with Verocay's observation and employed the more appropriate term "Schwannoma" following his description of experimental and spontaneous schwannomas. Stout,<sup>14</sup> in 1935, after further histologic study, proposed the term "neurilemmoma," urging, as did Mas-

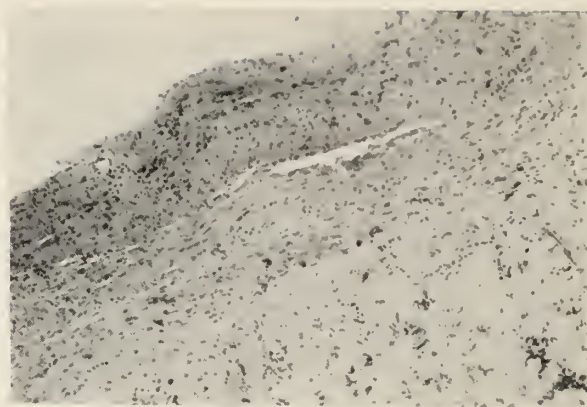


FIG. 1. Neurilemmoma exhibiting characteristic lamellated capsule and Antoni type A tissue with palisading of cell nuclei in lower right corner.

son, that the tumor was of neuroectodermal or Schwann cell origin. Tissue culture observations by Murray and Stout<sup>15</sup> in 1940 rendered additional support to this concept. The nerve sheath cell (Schwann cell) is now generally believed to be the cell of origin.

*Clinical Features:* The most frequent presenting complaint is that of a painless, gradually enlarging, lateral neck mass. These tumors may become quite large, producing a pressure or choking sensation in the throat. A spasmodic, unproductive cough induced by manipulation of the tumor is occasionally noted and, when present, is considered pathognomonic.<sup>6,7</sup> The tumor may appear at any age, affecting both sexes equally. On palpation, the lesion is frequently a round-to-ovoid, firm, non-tender mass usually found behind the anterior margin of the sternomastoid muscle, and it may appear at any level in the distribution of the carotid sheath. Lateral motion is frequently demonstrated. Characteristically, the nerve function is rarely disturbed and pain, when present, is usually due to pressure on adjacent structures. A case presenting with Horner's syndrome has been reported,<sup>2</sup> but this is rare. While the diagnosis is rarely made preoperatively, the features described, in the absence of oral disease, should suggest the possibility of neurilemmoma.

*Gross and Histologic Features:* In general, these neoplasms are of firm consistency, encapsulated and encompassed by or eccentric to the nerve fibers. These fibers are attenuated and splayed out over the capsule of the expanding tumor. Neurilemmomas as large as 10 X 5 cm in size have been reported.<sup>2</sup> These large tumors are likely to undergo myxomatous degeneration.<sup>9</sup> Hemorrhage within large vacuoles and fluid-filled cystic spaces may impart a fluctuant consistency to palpation. The cut surface is often gray-white to tan in color, glistening, trabeculated and mottled by pink-to-



dark hemorrhagic areas of cystic degeneration. The lamellated capsule of perineurium<sup>9</sup> may be traversed by small nerve filaments but, characteristically, the nerve fiber does not penetrate into the substance of the tumor.

Histologically, two types of tissue patterns have been described.<sup>16</sup> The Antoni type A component is composed of an orderly array of spindle-shaped cells aligned in parallel bundles or whorls. Palisading of the small round nuclei is a characteristic feature which is diagnostic (Fig. 1). In other adjacent regions a loose, less organized, reticular pattern with cell nuclei in haphazard array is characteristic of the Antoni type B tissue. Masson believes that these areas represent foci of degenerative "fibrosis" in which macrophages, lipoid vacuoles, and hyalinization of connective tissue surrounding capillary endothelium may be seen.

### Comment

Neurilemmoma of the vagus nerve is a rare, benign tumor derived from the neurilemma or nerve sheath of Schwann. The lesion rarely produces symptoms referable to the nerve of origin and, as a result, the diagnosis is rarely entertained preoperatively. In the absence of oral disease, it should be considered in the differential diagnosis of an asymptomatic, lateral neck mass.

Recurrence has not been reported after extracapsular enucleation. Intracapsular enucleation is reported by Paul<sup>17</sup> but follow-up is not mentioned. In the majority of cases reported, removal of the lesion was performed with segmental resection of the vagus nerve. End-to-end anastomosis and nerve-grafting procedures have been employed.<sup>8,18</sup> Complete return of nerve function has been reported two years after a great auricular nerve graft.<sup>8</sup>

Vocal cord palsy has been observed postoperatively in all the cases compiled prior to a recent report by Holland.<sup>6</sup> This case report by Holland is unique in that enucleation was accomplished with preservation of vagus nerve function. The effects of cervical vagectomy depend upon the level at which the vagus nerve is interrupted. The deficit is usually in the distribution of the recurrent laryngeal nerve and rarely is the superior laryngeal involved unless the lesion is a high one, involving this nerve at the level of the nodose ganglion. Lemere<sup>19</sup> has given a detailed anatomic description of the effect of unilateral and bilateral recurrent and superior laryngeal nerve deficits on the larynx.

At the time of surgery, the decision to perform an enucleation or segmental nerve resection is an important one. Whether enucleation is employed will depend upon the degree to which the nerve is adherent to the underlying tumor capsule. In the case reported here, difficulty was encountered

at the superior and inferior poles where the capsule was bound to the perineurium of the parent vagus nerve. In this regard, Masson,<sup>9</sup> after detailed histologic observations, has emphasized that the capsule is characteristically formed of lamellae which are not fixed to the underlying tumor. This facilitates enucleation of the tumor. At the superior and inferior poles the capsule may be in continuity with the perineurium of the parent nerve but the parent nerve does not penetrate beneath the capsule into the substance of the tumor. The fibrous connective tissue within the tumor does not represent endoneurial proliferation but rather is derived from degenerating or "sclerosing" Schwann cell syncytium.<sup>9</sup> A reassessment of these histologic features in conjunction with a benign frozen-section diagnosis lends support to considerations for intracapsular enucleation when extracapsular enucleation is not possible.

### Summary

A rare case of neurilemmoma of the cervical vagus nerve is presented. Considerations are given to the clinical, surgical, and pathologic features of this tumor. While the tumor is a rare, benign, encapsulated lesion, it is problematic because of its location. The diagnosis should be included in the differential diagnosis of an asymptomatic, gradually enlarging lateral neck mass—in the absence of primary or metastatic malignant disease. The deficit to laryngeal function with the interruption of vagal nerve fibers may be expected to improve following enucleation or nerve-grafting procedures. Consideration is given to a more conservative surgical approach, intracapsular enucleation, when extracapsular enucleation is not possible.

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## NEPHROLOGY

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# The Sickled Kidney

LEONARD B. BERMAN, M.D.

IT IS FITTING that the shape of a sickled red cell should resemble that of a kidney. The patient with sickle trait or disease is liable to experience several types of sickle cell nephropathy. The best known of these is gross hematuria, seen most often with the trait. The bleeding arises just beneath the pelvic mucosa, where masses of sharp-pointed sickled red cells engorge and rupture venules. The low oxygen tension and interstitial hypertonicity, which are characteristic of the renal medulla, undoubtedly favor the formation of these sickle cell masses. The same concept applies to the second of the nephropathies, papillary necrosis. This is a slowly developing process affecting one papilla at a time and is not associated with acute

renal failure. The third nephropathy is the nephrotic syndrome, associated with glomerular microinfarcts, resulting from plugs of sickled red cells. It is uncommon and unresponsive to steroid therapy. The same problem on a macroscopic scale leads occasionally to renal infarctions, which is the fourth nephropathy. The fifth problem is inability to concentrate the urine, related to disturbances of the countercurrent mechanism. This, in turn reflects the slowing of the medullary blood circulation by sickled cells. The sixth and last nephropathy is pyelonephritis. This vulture of renal diseases flies around looking for dead or dying nephrons to land on. The sickle cell kidney unfortunately provides numerous opportunities for bacterial lodgement and growth. Thus, the patient with hemoglobin S may have his life further burdened with hematuria, nephrotic syndrome, necrotic papillae, pyelonephritis, and finally, renal failure.

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\*Dr. Berman is Chief of the Department of Nephrology, Mt. Sinai Hospital of Cleveland.

# Heart Attacks and Education of the Public

SOME MEDICAL catastrophies are so great that a call to a medical emergency system is almost a reflex. The events leading to sudden death from coronary artery disease may be much more subtle. It is disturbing to realize that of the more than 600,000 deaths per year from coronary heart disease in the United States, over half of the patients never reach the hospital. In a broad attack on this staggering death rate, we have seen in the past decade the development of hospital-based coronary care units, mobile coronary care units, and greater attention to the emergency and early care of heart attack victims. One aspect of this becomes quite clear. The patient must realize the early warning signs and recognize when to report his symptoms and seek medical care. He should be aware of the urgency of their evaluation. The report in this issue by Black and Brown (see page 369) is of particular interest. It shows that a public information campaign can produce a significant reduction in delay time between the onset of myocardial infarction and entrance to the coronary care unit. Furthermore, they show that the person-to-person method utilized is not only effective, but inexpensive as well. They are to be commended on this interesting and provocative study demonstrating an important lesson.

Aside from its more specific meaning in coronary artery disease, this study raises important questions about what the physician should tell his patients to do in case of emergency. Undoubtedly, this will depend heavily upon the nature of the illness and the resources available in the community, but as facilities change, the physician should reassess what he tells his patients. It may be in the best interest of the patient who suspects

a heart attack to seek out the emergency care system in his area, rather than call the physician himself. In many communities, the non-toll telephone number 911 is becoming the avenue for patients with such acute medical problems. The day is past when emergency rooms are thought of as trauma units. Today, especially in large metropolitan areas, trauma may constitute as little as 10 percent of the activity of the emergency room.

It is sometimes feared that teaching a patient about the early symptoms of disease will produce a population of neurotics, ready to pick up the telephone at the slightest symptom. The Columbus Fire Department has maintained a medical emergency system available to all for many years. They have found that the citizens of this community have not misused their system. There are unnecessary calls, of course, but the number and incidence have not increased with the institution of the so-called Heartmobile program providing early treatment to heart attack victims.

Public education, however, is not the entire answer. Our experience in early coronary care indicates that the person who has one, two, or three myocardial infarctions will delay more than the person with the first evidence of heart disease. It is well recognized that such patients may deny that new symptoms are related to a heart attack. In patients with angina pectoris, there is often the tendency to ascribe a given episode to just another case of angina and not a new cardiovascular event.

The study reported here, therefore, represents an important addition to the mosaic being developed to provide the citizens of this country with a well-organized and properly utilized system of emergency medical care. The role of the physician is crucial, yet he cannot do it all. Much of it is in the hands of the various health planners and community agencies. Physicians should become involved and provide the leadership and guidance to make this a first-class medical resource available to all.

James V. Warren, M.D.  
Guest Editor

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Dr. Warren, Professor and Chairman of the Department of Medicine at The Ohio State University College of Medicine, has been very active in promoting the "pre-hospital" care of people with heart attacks and is well known for developing the Heartmobile program in Columbus.

—The Editor

Submitted March 6, 1973.

# Professional Activities



## Proceedings of The Council

Meeting of March 16-18, 1973

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Friday, Saturday and Sunday, March 16, 17 and 18, 1973, at the OSMA Headquarters' office, 17 S. High Street, Columbus, Ohio.

Those present Friday evening were: All members of the Council (except Dr. William R. Schultz, Wooster; Dr. James L. Henry, Grove City; Dr. James G. Tye, Dayton, and Dr. Thomas W. Morgan, Gallipolis); Dr. Richard L. Meiling, Columbus, Chairman of the Ohio Delegation to the AMA; all members of the OSMA executive staff, and Mrs. Gail Dodson.

Those present Saturday were: All members of the Council (except Dr. Henry); Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Dr. John H. Budd, Cleveland, a member of the AMA Board of Trustees; Mr. Bernard D. King, Columbus, Student AMA Representative; Mr. William J. Lee, Columbus, Administrator of the Ohio State Medical Board; Dr. James I. Tennenbaum, Columbus, President of the Ohio Society of Allergy and Immunology, all members of the OSMA executive staff, Mr. R. Gordon Moore and Mrs. Gail Dodson.

Those present Sunday were: All members of the Council, Mr. Pohlman, Dr. Budd, Dr. Sol Maggied, West Jefferson, representing the OSMA Joint Advisory Committee on Sports Medicine, and all members of the OSMA executive staff.

### Minutes Approved

Minutes of the meeting of January 27-28, 1973, were approved.

### Councilor Reports

The Councilors reported on activities in their respective districts.

### Finance and Membership

The membership statistics were presented by Mrs. Wisse.

The Council discussed dues for the category "Members in Training," in anticipation of the possible adoption of a resolution establishing this category of membership at the 1973 House of Delegates. The Council instructed the Membership Department to make a cost determination of basic services to these members for presentation at the next meeting of the Council.

The Council ratified its sponsorship of Resolution No. 56, which had been submitted by officers of the Association. Such resolution would establish a new category of active membership to be designated "Life Active Membership," for consideration by the 1973 House of Delegates.

### American Medical Association

Dr. Meiling reviewed developments at the American Medical Association, with emphasis on the work of the Council on Long Range Planning and Development.

The Council voted to publish in *The Ohio State Medical Journal* the Ohio position paper on Report "H" of the Council on Medical Education, "Function and Structure of a Medical School," which was referred by the AMA House back to



the Council on Medical Education, at the insistence of the Ohio Delegation during the 1972 Clinical Session of the American Medical Association. The Council also requested that the Delegation submit a resolution on Report "II" to the 1973 Annual Session of the AMA House.

The Council considered a request from another state asking support of a resolution to request that the AMA reestablish its membership with the World Medical Association. The opinion expressed by The Council is as follows:

"We recognize the value of the World Medical Association, we feel it should be supported by individual physicians, and will urge our members to do so. Financial support by the American Medical Association as an entity would not, therefore, be indicated under these circumstances."

The Council discussed proposals under consideration by various AMA committees and councils to provide for AMA delegates from specialty societies, as well as specialty sections, a move which would not be in conformity with Ohio Resolution No. 14, adopted by the AMA House of Delegates, June 18-22, 1972. It was agreed that a letter should be sent to the State Association presidents, alerting them to these developments.

### **Intern and Resident Matching Program**

With regard to the National Intern and Resident Matching Program policies, the Council voted to present and support resolutions at the AMA level objecting to a matching program for residents which requires that the hospital have all of its program in the NIRMP Matching Plan or none. It was the expression of the Council that the hospital staff should have the option of selecting residents outside the matching program.

### **OSMA Annual Meeting**

A progress report on the Annual Meeting was presented by Mrs. Dodson.

The Council agreed that consideration of the format of the 1974 Annual Meeting, as well as future Annual Meetings, should be on the Council agenda as soon as possible after the 1973 meeting.

The possibility of an art show at the Cleveland meeting was discussed and Mrs. Dodson was instructed to request a proposal from Cleveland physicians who have shown interest in such a project.

The Council received 57 resolutions filed under the 60-day rule of the Constitution and Bylaws.

### **Constitution and Bylaws**

Amendments to the Constitution and Bylaws of the Lake County Medical Society were approved.

The revised Constitution and Bylaws of the Huron County Medical Society was approved.

An amendment to the Constitution and Bylaws of the Clermont County Medical Society was approved.

### **Medical Advances Institute**

Dr. Henry reported on the PSRO Council meeting, February 21, 1973, the MAI Hospital Liaison meeting of February 21, and the MAI Board of Trustees meeting of March 7.

Dr. Henry announced that he had resigned as President of Medical Advances Institute, and that Dr. Robert R. Clark, of Akron, had been elected to succeed him as President.

### **Building Committee**

Mrs. Wisse presented the Building Committee minutes of January 28 and March 7, and they were approved.

The Council adopted the following resolution:

"RESOLVED, That James L. Henry, Secretary-Treasurer, be authorized to sign a contract in form approved by counsel for the Association and the Building Committee, for the construction of the new headquarters building at 600 South High Street, Columbus, Ohio, with Tri-Star Construction Company, as contractor, for a price not to exceed \$500,000, and with Kevin Flaherty, as architect, whose fees for services shall be paid by, and as a part of the contract price of, Tri-Star Construction Company; and

"BE IT FURTHER RESOLVED, That James L. Henry, Secretary-Treasurer, be authorized to negotiate a loan with The Huntington National Bank of Columbus, or such other lending institution as he may choose, for an amount not to exceed \$500,000 at such interest rate, terms and conditions as he deems advisable and to execute for and on behalf of Ohio State Medical Association a promissory note evidencing such loan to be secured by a first mortgage on the real estate located at 600 South High Street, Columbus, Ohio, for the purpose of constructing the new headquarters building; and that he be authorized to execute any and all other documents which such lending institution may require in connection with such loan."

### **Ohio Medical Indemnity, Inc.**

Dr. Robeck reported for the Liaison Committee of Ohio Medical Indemnity, Inc.

### **State Legislation**

Mr. Page discussed the following legislative proposals and the Council, after discussion of each,

established policy as indicated.

Legislative Service Commission draft 110-251, to establish an Ohio catastrophic health insurance plan. (Action: Actively oppose.)

Draft of the bill to amend the Medical Practice Act by eliminating a number of archaic groups from the statutes. (Action: Active support.)

Mr. Rader presented the following bills for consideration:

**H.B. 54**, to allow persons meeting qualifications established by the Director of Health to withdraw blood for tests under the implied consent law. (Action: No objection, if properly amended to require that such be done under a physician's direction.)

**H.B. 125**, to require the Department of Welfare to contract with a fiscal agent for processing Medicaid claims. (Action: Active support.)

**H.B. 126**, to provide for the payment of interest on unpaid Medicaid claims. (Action: No position.)

**H.B. 129**, to require the Department of Welfare to contract with a fiscal agent for processing Medicaid claims. (Action: Active support.)

**H.B. 163**, relative to the issuance and renewal of drivers licenses for persons suffering from epilepsy. (Action: Needs further study.)

**H.B. 168**, to require schools to distribute and keep on file emergency medical authorization forms. (Action: Active support, if properly amended.)

**H.B. 197**, to provide for a system of determining the shelf life of drugs, etc. (Action: Oppose as duplicating existing federal standards.)

**H.B. 202**, requiring the use of occupant restraining devices in automobiles. (Action: Support the concept, but the present engineering of shoulder and lap combination is not acceptable.)

**H.B. 266**, to create the Northeastern Ohio Universities College of Medicine. (Action: Support the concept of establishing further medical schools with the decision of locations, thereof, to be a matter for the Legislature to decide.)

**H.B. 296**, to provide for class D-7 liquor permits for hospitals and rest homes. (Action: No position.)

**H.B. 302**, to regulate abortion practices in Ohio. (Action: Referred to the Committee on Maternal Health for study, with the request that the results of the study be made available to the appropriate reference committee at the Annual Meeting of the Ohio State Medical Association, May, 1973. The Council further requested that the Committee on Maternal Health act as a resource group for the reference committee.)

**H.B. 341**, to provide for certification of school nurses by the Department of Education.

(Action: Referred to the Committee on School Health.)

**H.B. 397**, to require licensing of immunohematologists. (Action: Oppose, under OSMA/OHA moratorium on licensing.)

**H.B. 417**, regarding Workmen's Compensation. (Action: Needs further study.)

**H.B. 420**, omnibus drug abuse bill. (Action: Referred to Committee on Mental Health.)

**S.B. 37**, bill to prohibit the use of purchased blood. (Action: Oppose in present form.)

**S.B. 56**, to provide for medical school at Wright State University. (Action: Support the concept of establishing further medical schools with the decision of locations, thereof, to be a matter for the Legislature to decide.)

**S.B. 64**, to remove physicians and others from Blue Cross Boards. (Action: Active opposition.)

**S.B. 71**, to permit the Governor to reorganize the executive branch of the state government. (Action: Actively oppose.)

**S.B. 72**, to create the Northeastern Ohio Universities College of Medicine. (Action: Support the concept of establishing further medical schools with the decision of locations, thereof, to be a matter for the Legislature to decide.)

**S.B. 123**, relative to a College of Medicine within the Cleveland State University. (Action: Support the concept of establishing further medical schools with the decision of locations, thereof, to be a matter for the Legislature to decide.)

**S.B. 142**, to apply money due to Medicaid providers by the Welfare Department for more than a 60-day period to the reduction of the provider's state income tax. (Action: Actively support.)

**S.B. 149**, OSMA and Ohio Coalition bill to require the Department of Public Welfare to contract for processing of Medicaid claims. (Action: Active support. This bill is sponsored by Senator Morris Jackson, Cleveland, and 11 Republicans and 12 Democrats in the Senate.)

**S.B. 150**, eliminates necessity for the pre-audit of Medicaid claims by the State Auditor. (Action: Active support. OSMA and Ohio Coalition bill. The bill is sponsored by Senator Jackson, Cleveland, and 11 Republicans and nine Democrats in the Senate.)

### Federal Legislation

The Council voted opposition to the Kennedy Health Maintenance Organization Bill and authorized the Woman's Auxiliary to the Ohio State Medical Association to proceed with the program of opposition to this legislation. A special committee was appointed to develop a statement concerning health maintenance organizations, with



final approval of the statement delegated to President Schultz.

Mr. Edgar reported that Ohio has added two more sponsors to the AMA Medcredit Bill, bringing the total sponsors of this session's bill to 11 at this time.

Mr. Pohlman reported to the Council on the proposed rule of evidence in the Federal Court system to eliminate the physician-patient privilege. S. 583 has been introduced in the Congress to delay, for at least a year, the implementation of the new rules. The Council directed that Ohio Congressmen be contacted and OSMA position and support of this bill be made known to them.

Mr. Edgar was authorized to proceed with arrangements for a Washington Visitation late in May 1973.

### NBC Program

Mr. Edgar reported on developments concerning the NBC program, entitled "What Price Health?" The exposure of the misrepresentations in this program has led to serious consideration by certain Congressmen of legislation to provide supervision of the TV networks.

The President commended Mr. Edgar for the investigatory work he has done in connection with exposing this program and for his cooperation with the Academy of Medicine of Cleveland, the American Medical Association and Congressman Devine in making the public aware of the true facts.

### Committee Reports

#### Committee on Maternal Health

Minutes of the January 20-21 meeting of the Committee on Maternal Health were presented by Mr. Gillen. The Council **approved** the ready reference obstetric records covering five areas of obstetric care, as developed by the Committee.

The minutes as a whole were **approved**.

#### Committee on Environmental and Public Health

Minutes of the meeting of the Committee on Environmental and Public Health, of January 24, were presented by Mr. Rader. A question of checking each mother for rubella at the time of delivery and immunizing her, if necessary, was referred to the Committee on Maternal Health for study.

The Council amended a recommendation of the Committee with regard to smallpox immunization, asking that OSMA members be advised to notify their hospitals that hospital personnel should have smallpox immunization every three years. In addition, physicians working in a hospital setting be advised to have such immunization.

The Council agreed with the Committee that members should be made aware that local health departments can now provide cultures for free VD testing.

Patient education television spots were recommended by the Committee and this was accepted for information, because such a program is now pending in the OSMA Department of Public Relations.

The suggestion for a monthly paragraph on communicable diseases was referred to the Editor of *The Ohio State Medical Journal*.

The minutes as a whole were **approved, as amended**.

#### Ohio Coalition for Quality Health Care Committee

Minutes of the January 30, February 13 and March 1 meetings of the Ohio Coalition for Quality Health Care Committee were presented by Mr. Page and were **accepted for information**.

#### Joint Advisory Committee on Sports Medicine

Minutes of the February 21 meeting of the Joint Advisory Committee on Sports Medicine were presented by Mr. Clinger.

Involvement of osteopathic physicians and surgeons in the sports medicine program was **approved in principle** by the Council.

The Council **approved** the Committee's request that Dr. Shaffer write a letter to the head of the Mid-American Youth Athletic Association, expressing the views of the OSMA and the Ohio High School Athletic Association that the MAYAA super-tournament for pre-adolescents runs contrary to the principles of both organizations.

A program for the education of emergency room physicians on treatment of heat illness, including guidelines to be followed, was **approved** by the Council.

The minutes as a whole were **approved**.

#### Committee on Private Practice

The minutes of the February 21 meeting of the Committee on Private Practice were presented by Dr. Lieber.

At the recommendation of the Committee, the Council **adopted** the policy that statewide mandatory certification of need must be actively and forcefully opposed.

An eight-point statement with regard to certificate of need was **amended and adopted**.

The minutes were **approved, as amended**.

#### Committee on Medicine and Religion

Minutes of the February 21 meeting of the





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No calculations are needed, test interpretation is simple.

Any of the commonly used T<sub>4</sub> thyroid function tests (P.B.I., T<sub>4</sub> By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T<sub>4</sub> because they *all* measure T<sub>4</sub>. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.



**TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.**

(1) The onset of action of T<sub>4</sub> is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)<sup>1</sup>; (2) since SYNTHROID contains only T<sub>4</sub>, the potential for metabolic surges traceable to more potent iodides (T<sub>3</sub>) is eliminated.

| TEST                      | HYPOTHYROID               | SYNTHROID THERAPEUTIC NORMAL |
|---------------------------|---------------------------|------------------------------|
| P.B.I.                    | Less than 4 mcg %         | 6-10 mcg %                   |
| T <sub>4</sub> By Column  | Less than 3 mcg %         | 7-9 mcg %                    |
| T <sub>3</sub> (Resin)    | Less than 25%             | 27-35%                       |
| T <sub>3</sub> (Red Cell) | Less than 11%             | 11.5-18%                     |
| Free Thyroxine            | Less than 0.7 nanograms % | 0.7-2.5 nanograms %          |
| Murphy-Pattee             | Less than 2.9 mcg %       | 4-11 mcg %                   |



**AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.**

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Read the accompanying prescribing information for additional data or write Flint Laboratories.

**Choose the Smooth Road ...to thyroid replacement therapy**



PATIENTS CAN BE SUCCESSFULLY MAINTAINED ON A DRUG CONTAINING THYROXINE ALONE.

Thyroxine ( $T_4$ ) is, as you know, the major circulating hormone produced by the thyroid gland. It is also produced, in smaller amounts, and is active at the cellular level. For years it has been a working hypothesis among endocrinologists that  $T_4$  is converted by the body to  $T_3$ . In 1970 this process, called "deiodination," was demonstrated by Braverman, Ingbar, and Sterling<sup>2</sup>. It does convert to  $T_3$ , though the precise quantities are still being studied.

The conversion has been technically demonstrated during the administration of  $T_4$  to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, and the presence of  $T_3$  in these patients has been clearly shown.

## WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING $T_3$ ?

Very simple.  $T_3$  costs more to make synthetically than does  $T_4$ . So it is economically necessary for a synthetic thyroid medication containing  $T_3$  to cost more than one containing  $T_4$  alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID<sup>3</sup> because the  $T_3$  costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine ( $T_4$ ) to Triiodothyronine ( $T_3$ ) in Athyrotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

# Synthroid<sup>®</sup>

## (sodium levothyroxine)

THE FACTS ARE CLEAR AND HERE IS OUR OFFER.

FACTS: Synthetic thyroid drugs are an improvement over animal gland products. Patients, even athyrotic ones, can be completely maintained on SYNTHROID ( $T_4$ ) alone. Thyroid function tests are easy to interpret since they are predictably elevated when the patient adheres to SYNTHROID. Of all synthetic thyroid drugs, SYNTHROID is the most economical to the patient.

### OFFER:

Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for Injection is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.



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Morton Grove, Illinois 60053



Committee on Medicine and Religion were presented by Mr. Campbell and were accepted as presented.

#### Committee on Workmen's Compensation

Minutes of the March 3 meeting of the Committee on Workmen's Compensation were presented by Mr. Campbell. The minutes were approved as presented, including the recommendation that the Bureau be encouraged to continue with its program to issue pressure sensitive stickers listing BWC telephone numbers. Also, that the Bureau be encouraged to consult with Dr. Paul Y. Ertel, of Columbus, in a project to design a "common claims form."

#### Committee on Emergency and Disaster Medical Care

Minutes of the March 3 meeting of the Committee on Emergency and Disaster Medical Care were presented by Mr. Rader.

The Council accepted the Committee's statement approving the concept of emergency medical technician certification on a national basis and opposing bills for state licensure of emergency medical technicians.

Also approved, was the Committee's recommendation that a questionnaire be sent to county medical societies to find interested persons to establish local emergency medical services councils.

The minutes as a whole were approved.

#### Commission on Medical Education

Minutes of the March 7 meeting of the Commission on Medical Education were presented by Mr. Edgar.

The Council approved for submission to the House of Delegates in 1973 the report and recommendations of the Commission on Medical Education, as requested by the House in 1972. The Council voted to commend the Commission and to issue a special letter of thanks to its members.

#### Membership and Planning Committee

Minutes of the March 16 meeting of the Membership and Planning Committee were presented by Mr. Gillen.

The Committee's recommendations for a program of meeting with medical students was approved by the Council.

The Council approved the Committee's recommendation to accept the proposed computerized membership system. The choice of computer

firm was delegated to the Auditing and Appropriations Committee.

The report as a whole was accepted.

#### Council Fee Review Committee

The minutes of the March 16 meeting of the Council Fee Review Committee were presented by Mr. Gillen.

Case No. 1—(appealed) action deferred pending receipt of additional information.

Case No. 2—approved the recommendation of the Committee that a reasonable payment would be \$900.00.

Case No. 3—(appealed) approved the Committee's recommendation that the patient should be examined for rehabilitation and that the Bureau of Workmen's Compensation should pay the physician's fee.

Case No. 4—(appealed) rereferred to the Committee.

Case No. 5—(appealed) approved Committee's recommendation that the fee of the physician was reasonable under the circumstances.

#### Ohio Academy of Family Physicians

Dr. Schultz reported on a meeting with the officers of the Ohio Academy of Family Physicians, held February 28. The Council accepted his report and voted to encourage continued periodic meetings between officers of the OSMA and OAFP.

#### Cleveland Pilot Program on Anesthesiology

The Cleveland Pilot Program on Anesthesiology was discussed. It was requested that model physician assistant certification proposals of the National Federation of Licensing Boards be obtained for study when they become available.

#### Resolutions on Ohio Department of Public Welfare

The resolutions from the Geauga County Medical Society and the Muskingum County Academy of Medicine, critical of the Ohio Department of Public Welfare, were received for information.

#### Ohio State Medical Board

Mr. Lee discussed recent developments in examination, licensure and enforcement. He noted that the Bureau of Narcotics and Dangerous Drugs has opened an office in Columbus—such office being helpful to the Medical Board.

He asked for more assistance with local enforcement problems. The Council authorized a meeting of the county medical society executives





# Spasm reactor?

# Donnatal!

each tablet,  
capsule or 5 cc.  
teaspoonful  
of elixir  
(23% alcohol)

each  
Donnatal  
No. 2

each  
Extentab

|                                 |                               |                               |                               |
|---------------------------------|-------------------------------|-------------------------------|-------------------------------|
| hyoscyamine sulfate             | 0.1037 mg.                    | 0.1037 mg.                    | 0.3111 mg.                    |
| atropine sulfate                | 0.0194 mg.                    | 0.0194 mg.                    | 0.0582 mg.                    |
| hyosine hydrobromide            | 0.0065 mg.                    | 0.0065 mg.                    | 0.0195 mg.                    |
| phenobarbital                   | ( $\frac{1}{4}$ gr.) 16.2 mg. | ( $\frac{1}{2}$ gr.) 32.4 mg. | ( $\frac{3}{4}$ gr.) 48.6 mg. |
| (warning: may be habit forming) |                               |                               |                               |

**Brief summary.** Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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About 20 mg. Vitamin C in one baked potato (2½" diameter).

To many people the evening meal just isn't complete without potatoes. But your patient would have to eat 15 of them (skins and all!) to get as much Vitamin C as is contained in just one Allbee with C capsule taken daily. A bottle of 30 (month's therapeutic dose) supplies as much ascorbic acid as 450 potatoes, plus full therapeutic amounts of the B-complex vitamins. For the patient who is counting calories, Allbee with C is small potatoes because the B's and C are water soluble. Consider the number of calories in 15 potatoes, not to mention the mountain of butter and sour cream. Allbee with C is available at pharmacies in the handy bottle of 30 and the economy size of 100 on your prescription or recommendation.

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for the near future and asked that Mr. Lee be invited to discuss local enforcement problems with this group.

### High School Athlete Insurance

Dr. Sol Maggied addressed the Council with regard to his conferences with Ohio Medical Indemnity, Inc., on providing insurance for high school athletes. The Council requested that a concrete proposal be brought to it for consideration at a future date.

### Greene County Memorial Hospital

Dr. Tye reported to the Council on developments at the Greene County Memorial Hospital.

### Jejunio-ileostomy

In answer to a communication from CHAMPUS, the Council advised that the procedure "jejunio-ileostomy" is not an experimental procedure in Ohio.

### Section on Allergy

Dr. Tennenbaum appeared before the Council to request approval for a Section on Allergy. The Council approved a Section on Allergy and appointed Dr. Tennenbaum as the organizing chairman. Such approval was granted with the understanding that the section will be open to allergists of various specialty backgrounds in addition to those with training in pediatrics and internal medicine.

### Section on Emergency Medicine

A request for the establishment of a Section on Emergency Medicine was referred to the Committee on Emergency and Disaster Medical Care for coordination and the working out of agreements with the Ohio Committee on Trauma, American College of Surgeons.

### Physicians' Assistants

With regard to a communication from the Cuyahoga Community College with regard to physicians' assistants, and another from the Ohio Bureau of Employment Services, the Council instructed that these correspondents be advised that this problem is in need of considerable study and the Association is in the process of preparing background material and legislation.

### U.S. Pharmacopeia

Dr. William H. Havener, Columbus, was selected by the Council to be the Ohio State Medical Association representative to the United States Pharmacopeia Convention.

### Blood Policy

With regard to correspondence from Dr. Daniel J. Hanson, President of the Ohio Society of Pathologists, concerning the proposed National Blood Policy of the Department of Health, Education, and Welfare, the Council voted to support the contention of the Ohio Society of Pathologists that the inspection and accreditation programs of the American Association of Blood Banks and of the College of American Pathologists be used in the conduct of the certification portion of the National Blood Policy.

### CPT Code for Abortion

With regard to a request from the Ohio Department of Public Welfare for a suggested CPT Code for abortion, it was the suggestion of the Council that the Department request information from the American Medical Association with regard to the third revision of the "Current Procedures Terminology."

### Early and Periodic Screening, Diagnosis and Treatment

Concerning a communication from Dr. M. S. Dixon, Jr., Wooster, Ohio, Chairman of the Ohio Department of Welfare Subcommittee on Early and Periodic Screening, Diagnosis and Treatment, the Council **concurred in principle** with Dr. Dixon's opinions, expressed in a letter dated February 28, that the screening exam should be a health assessment under the supervision of physicians and hopefully in the same setting where a child will receive continuing primary care. The mass examination approach done outside the indigenous health system should be discouraged, and that with regard to compensation, the present usual and customary system be used rather than a flat fee. The Council **endorsed in principle** a screening program of the above nature on the basis that it be done in a regional or county area in order to make evaluation of the program possible.

### Nurses Home Planning Group

In answer to a request from the Ohio Regional Medical Program, asking OSMA to appoint a representative to serve on the ORMP Nurses Home Planning Group, the Council selected Dr. Milton W. Gwinner, of Cincinnati.

### Commission to Study Nursing Needs and Resources

In response to a request from the Ohio Director of Health, asking for the designation of a



physician to assist with a study of the nursing needs and resources in Ohio, Dr. Jeanne H. Stephens, Oberlin, was appointed by the President and approved by the Council.

#### Dr. Robechek Commended

It being the last official meeting of the Council involving Dr. Robechek as Past President, the Council expressed its appreciation for his fine leadership as Councilor, President-Elect, President and Past President. Dr. Robechek responded, saying that his association with the Council has been one of the most rewarding experiences of his professional career.

#### Thanks the Council

Dr. Schultz thanked the members of the Council for their support during his presidential term and for their dedication to the work of the Ohio State Medical Association.

#### Next Council Meeting

The next meeting of the Council will be the "think session" to be held at the Wooster Inn, Wooster, Ohio, and scheduled for 10 a.m., Saturday, March 31 and ending mid-morning Sunday, April 1.

ATTEST: Hart F. Page  
*Executive Director*

AVAILABLE FOR THE TREATMENT OF

# impotence

due to androgenic deficiency in the American male.



**Android<sup>®</sup> 5** MUQUETS  
BUCCAL Tabs  
Methyltestosterone N.F. - 5 mg.

**Android<sup>®</sup> 10**  
Methyltestosterone N.F. - 10 mg.

**Android<sup>®</sup> 25**  
Methyltestosterone N.F. - 25 mg.

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosterone-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating male for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration of excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

| INDICATION   | Average Daily Dosage Tablets |
|--|------------------------------|
| In the male:   |                              |
| Eunuchoidism and eunuchism   | 10 to 40 mg.                 |
| Male climacteric symptoms and impotence due to androgen deficiency | 10 to 40 mg.                 |
| Postpubertal cryptorchism  | 30 mg.                       |

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

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2500 West 6th Street, Los Angeles, California 90057



## Directory Lists Sources of Help in Drug Abuse Field

Copies of the 80-page Ohio Directory of Drug Programs, published by the Bureau of Drug Abuse, Ohio Department of Mental Hygiene and Mental Retardation, are available as a public service from the OSMA office.

Copies may be obtained by contacting the Secretary, Committee on Mental Health, Ohio State Medical Association, 17 S. High St., Suite 500, Columbus, Ohio 43215, (614) 228-6971.

The directory lists more than 230 drug abuse prevention and treatment programs currently operating in Ohio. It was published following a state-wide survey of programs and services by the Bureau of Drug Abuse.

According to the Bureau "the directory is an initial attempt to illustrate the many modalities involved in drug treatment in Ohio. It is not intended to be an approving device. Therefore, programs listed in this directory are not necessarily endorsed by the Bureau of Drug Abuse or the Department of Mental Hygiene and Mental Retardation. Accordingly those programs which, for whatever reason, do not appear in this publication cannot be assumed invalid or ineffective. We feel this directory will enable programs in Ohio to become aware of one another in the hope that cooperative endeavors for improved client services will be pursued. Also the program listings will be an excellent source of information for persons seeking assistance."

The programs in the directory are listed both by counties and on an alphabetical basis.

## Family Practice Board Announces Examinations

The American Board of Family Practice announces that it will give its next two-day written certification examination on October 20-21, 1973 in various centers throughout the United States. Information regarding the examination can be obtained by writing:

Nicholas J. Pisacano, M.D., Secretary  
American Board of Family Practice, Inc.  
University of Kentucky Medical Center  
Annex #2, Room 229  
Lexington, Kentucky 40506

It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in the Board office is August 1, 1973.



## BARRY STINGING INSECT ANTIGEN

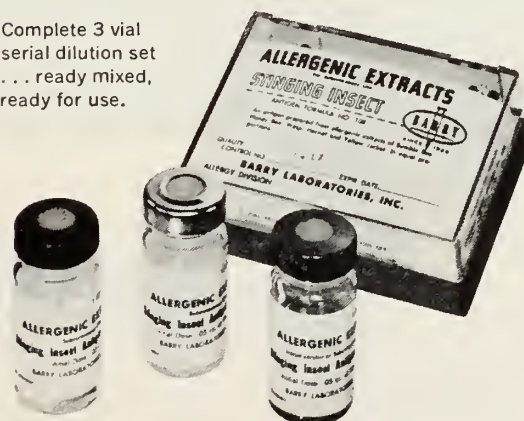
*protection for patients  
who have had severe  
reactions to stings of  
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YELLOW JACKETS*

Serious complications can and do arise in persons hypersensitive to stings of these insects. Persons showing sensitivity usually show a *progressive* increase in the severity of reactions to subsequent stings.

Barry STINGING INSECT ANTIGEN No. 108 (allergic extracts) is a combined insect antigen designed to protect patients from severe reactions to future stings by immunization. This balanced stock formula is a polyvalent whole-body extract of wasp, hornet, bumble bee, honey bee and yellow jacket antigens; and offers cross protection against stings of any of these insects.

For administration and dosage see prescription package circular.

Complete 3 vial  
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**Complete Allergy Service Since 1928**



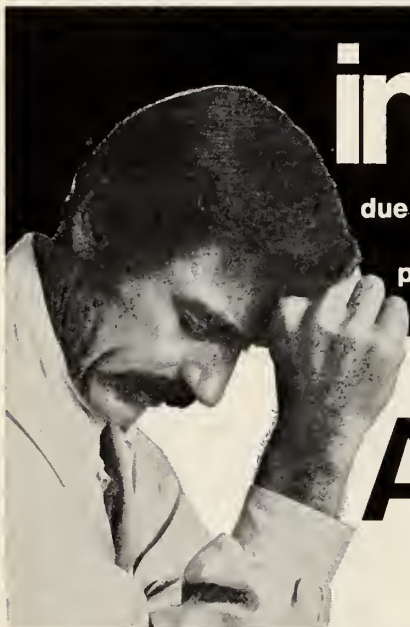
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due to androgenic deficiency in the American male.  
 The concept of chemotherapy plus the  
 physician's psychological support is confirmed  
 as effective therapy.

**NEW  
 CLINICAL  
 STUDY**

The Treatment of Impotence  
 with Methyltestosterone Thyroid  
 (100 patients — Double Blind Study)  
 T. Jakobovits  
 Fertility and Sterility, January 1970  
 Official Journal of the  
 American Fertility Society

**Android**<sup>®</sup>  
 (thyroid-androgen) tablets



**Double-Blind Study and Type of Patient:**

100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

**Choice of 4 strengths:**

**Android**

Each yellow tablet contains:  
 Methyl Testosterone .25 mg.  
 Thyroid Ext. (1/6 gr.) .10 mg.  
 Glutamic Acid .50 mg.  
 Thiamine HCL .10 mg.  
 Dose: 1 tablet 3 times daily.  
 Available:  
 Bottles of 100, 500, 1000.



**Android-HP**

HIGH POTENCY

Each red tablet contains:  
 Methyl Testosterone .50 mg.  
 Thyroid Ext. (1/6 gr.) .30 mg.  
 Glutamic Acid .50 mg.  
 Thiamine HCL .10 mg.  
 Dose: 1 tablet 3 times daily.  
 Available:  
 Bottles of 100, 500, 1000.

**Android-X**

EXTRA HIGH POTENCY

Each orange tablet contains:  
 Methyl Testosterone .125 mg.  
 Thyroid Ext. (1/6 gr.) .64 mg.  
 Glutamic Acid .50 mg.  
 Thiamine HCL .10 mg.  
 Dose: 1 or 2 tablets daily.  
 Available:  
 Bottles of 60, 500.

**Android-Plus**

WITH HIGH POTENCY  
 B-COMPLEX AND VITAMIN C

Each white tablet contains:  
 Methyl Testosterone .25 mg.  
 Thyroid Ext. (1/6 gr.) .15 mg.  
 Ascorbic Acid (Vit. C) .250 mg.  
 Thiamine HCL .25 mg.  
 Glutamic Acid .100 mg.  
 Pyridoxine HCL .5 mg.  
 Niacinamide .75 mg.  
 Calcium Pantothenate .10 mg.  
 Vitamin B-12 .25 mcg.  
 Riboflavin .5 mg.  
 Dose: 2 tablets daily.  
 Available: Bottles of 60, 500.

**Contraindications:** Android is contraindicated in patients with prostatic carcinoma, severe cardiovascular disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

**Warnings:** Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

**Precautions:** If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

**Adverse Reactions:** Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

**References:** 1. Montesano, P. and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titeff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypochlosteremic effect of androstene. J Clin Endocr 19:536, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the male. Thomas, Springfield, Ill., 1959, pp. 79-99.

Write for literature and samples: **BROWN** THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057



## EDITORIAL COMMENT

### The Journal Is a 'Bridge,' Linking Physicians and OSMA

Little indicators sometimes add up to all-important conclusions.

In the recent issue of *The Ohio State Medical Journal*, an offer was made to furnish readers on request with several papers on drug abuse. The offer was made in a small article occupying less than a column of space.

Within a short time, requests had come from physicians in such diverse areas of the State as Youngstown, Dayton, Cleveland, Cincinnati, Akron, Toledo, Columbus, Ross County, Fulton County, Wood County, etc. Most of the notes were from practicing physicians in Ohio, but represented in the requests was a medical librarian, an industrial firm, and even a nonresident member of the Association in Florida.

That was one little item out of some 80 pages in one issue of *The Journal*, but the experience is an indication of the many services offered by the Association to its members, and further, it is an indication that physicians are responding to those services.

Some physician members indicate that they read *The Journal* from cover to cover each month. We don't expect them all to do that, but it is a good idea to scan each issue for information of interest to you. You'll be surprised how many items of interest you'll find over a year's time.

We hear a great deal about communication gaps in our fast-moving and fast-changing pace, and such gaps are of real concern. Make *The Journal* a 'bridge of communication' between you and your Ohio State Medical Association and between you and your colleagues throughout the State.

The Fort Steuben Academy of Medicine met on April 10 at the Steubenville Country Club, Steubenville. Guest speaker was Dr. Robert N. Clark, Chairman of the Division of Orthopedic Surgery at the University of West Virginia whose subject was, "Thromboembolism."

This year marks the 50th anniversary of the first graduating class from what is now the Holzer Medical Center School of Nursing in Gallipolis. Mrs. Sara Bush, R.N., is heading up an arrangements committee for the celebration June 8-10.

### Radiologists Study Black Lung Disease

The American College of Radiology, 20 N. Wacker Drive, Chicago, Illinois 60606, recently released a report on a study entitled, "Occupational Disease X-Ray Surveys: The Black Lung Experience."

The report indicates that by October 1972 some 63,000 miners have received x-ray examinations in keeping with the provisions of Public Law 91-73, passed by the Congress in 1969.

Of four principals who participated in the forum study, one is an Ohioan. He is Jerome F. Wiot, M.D., of Cincinnati, chairman of the American College of Radiology Clinical Training Committee on Black Lung, member of the ACR Task Force, professor of radiology at the University of Cincinnati, and director of radiology at Cincinnati General Hospital.

Dr. R. R. Schwalenberg was one of two local citizens honored at the Ladies Night Banquet of the Tiffin Area Chamber of Commerce for his numerous civic contributions.

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**(See Page 402)**

# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

BY THE TIME this column is read in May, the year will have drawn to a close for Mrs. Louis Loria, 1972-73 president of the Woman's Auxiliary to the Ohio State Medical Association. It has not been customary to give accolades to retiring presidents in this column which, I realize belatedly, has been a serious oversight.

Any woman who assumes the presidency of the State Auxiliary gives so much of herself to the job that it is difficult to comprehend and appreciate fully. We owe her a deep debt of gratitude. Those of us who have worked with Eileen Loria on the State Board know well what she has given to the auxiliary. But to the doctors and even doctors' wives throughout the state to whom the name of the president is better known than the lady herself, (even though Eileen has "visited" with many, many groups) it seems fitting at this time to point out that we have had a conscientious, interested, competent, keenly aware leader who has never spared herself and who has always had a sympathetic ear for anyone and everyone!

To Eileen Loria, our own "printed" orchid for a job well done! And to Dr. Louis Loria, our grateful thanks for letting the auxiliary share her with you!!

## Doctors Watch Weight?

From Mrs. Robert Krone, state nutrition chairman, comes a rather "illuminating" article she had read in "Medical Opinion" recently. "Perhaps you can use a quote or two from it,"

Fran writes. "Perhaps you can pitch the words of advice to the wives who look after the husbands, or to the doctor-husbands who are reading the column." Fran Krone's suggestions are always too good to turn down! Here are some of the quotes from the article in "Medical Opinion":

"Physicians watch their waistlines almost as warily as they scrutinize the actions of Congress," the latest Physicians' Attitude Survey indicates. Although the greatest percentage of respondents place themselves within generally-accepted height-weight-norm, nearly half are currently on a diet of some sort. One in four never has dieted, but the overwhelming majority have been on a weight-watching program recently, at least in the past five years . . .

"The rigors of practice have stabilized the weight of a third of the respondents at about the same level they enjoyed ten years ago. But a ponderous 44 percent have gained in the last decade. . . . Calorie control is the focus of the dietary program in half of the instances confessed. The majority of the remainder try to cut down on a number of food elements, but only six percent concentrate on saturated fats or cholesterol . . . physician-respondents did not seem to place much emphasis on these villains in their own personal diet. Personal appearance was the main rationale for a weight control program in the largest number of instances, quite a number cited a 'combination of reasons' for past bouts with the palate. . . .

"If one specialty could be said to be more weight-conscious than another, surgeons would get

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## THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

---

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Bristolville, 44402

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the nod. Nearly half of these currently are dieting. Younger physicians were more likely to have experienced recent weight gains . . . respondents under 40 years of age were more than twice as likely to diet for reasons of personal appearance than were those over 50—who were in turn three times more likely to be concerned about the danger of heart attacks. . . .

"The focus for the dietary programs used by physicians, when done for non-medical reasons, is overwhelmingly the cunning calorie. Interpretations of the results of this diet questionnaire over the profession as a whole would be hazardous. It does establish that physicians are as concerned as the general public about their waistlines—whether for reasons of vanity or for good health. No effort was made to assess chronic overweight, only gains of a comparatively recent nature. . . ." The article ends with the suggestion that the weight-concerned physician should attend a future meeting of his county medical society and steal a glance at his seated colleagues! (More on weight and nutrition from Mrs. Krone next month) - - -

#### From Washington, D.C.

And Mrs. Malachi W. Sloan, II, North Central Regional Legislative Chairman and OMPAC Board member: "There was a different tone to all the AMPAC meetings this year. It seemed as though we had matured considerably and panic had given way to a more sophisticated and confident approach to the whole scene of government versus medicine."

The March 10 and 11 meetings at the Washington Hilton Hotel presented outstanding speakers, a meaningful panel presentation and work-

shops. Dr. Charles A. (Carl) Hoffman, AMA president, gave the opening address, saying that "we may wish to be left waiting at the church but the climate today indicates otherwise . . . throwing tax money into the breach is not the answer to pressing social problems . . . we must seize the opportunity we have under the present administration."

Ohio's Dr. Jack Lewis, of Dayton, is the new AMPAC chairman, succeeding Dr. Hoyt Gardner, of Kentucky. Says Mrs. Sloan: "He challenged us all with his 'Instant Replay', his emphasis that PAC membership is vital, and pointing out the good record AMPAC had in the 1972 elections. He reflected optimism about the 'improved situation' in Washington, D. C.

"The panel presentation was fun and helpful. The participants had each made political predictions last year, and some of these predictions came back to haunt them! Uppermost in everyone's mind is National Health Insurance. We were told several times that there would be no such bill this year—hearings, yes, but no action. The feeling is strong that we do have our chance to present the strong basic ideas of the AMA."

Jane described the workshop sessions as excellent, particularly the one on "Communication." The phrase "Class Up Your Act" really caught her imagination (and, knowing Jane, I'm looking forward to those "spectaculars" she'll be coming up with!) Particularly since she and Mrs. S. B. Pfahl, Ohio's legislative chairman, were in Washington together and simultaneously "charged" with enthusiasm! If any two women can make the impossible possible, they're the two to do it. . . .

In speaking of the Saturday night dinner, Mrs. Sloan commented "Ohio didn't win any

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awards, but it was exciting to hear about those who did." And there was a Sunday morning Breakfast Session for the women at which Jean served as a hostess. The breakfast came about because in the past the doctors' wives at the workshop often felt "left out" of PAC, even though they provided much of the brawn! Our two Ohioans learned how other states attack the problem of apathy among our women where PAC is concerned.

And speaking of AMPAC-OMPAC, it isn't too late for any auxiliary member (or doctor!) to send in membership dues of \$25. It's the one outstanding "commodity" that hasn't had any price raise. . . . It's also not too late for "Legislative Alert"—the sending of letters to Ohio's Senators Saxbe and Taft, opposing S-14, the Kennedy Health Main, Organization Bill. In Illinois, doctors' wives have sent over one thousand letters to their senators.

### Seven Thousand Dollars!

Would you believe that any auxiliary anywhere could come up with a one-night benefit "show" that netted some seven thousand dollars? Well, you'd better believe it! Because that is exactly what the Licking county auxiliary did on a memorable Saturday night in March for its paramedical scholarship project.

The scene of activity was the beautiful Granville Inn where more than 350 eager auction fans turned out for Licking county's First Annual Benefit Auction and champagne buffet. I had the opportunity recently to talk to Mrs. Frederick N. Karaffa, general chairman and she said the entire lounge-parlor area of the Inn was one happy "mob scene" long before the guests and patrons had been wined and dined, and before the auctioneer Jim Peddicord (who donated his services) went to work! There were objects of every variety, value, description and appeal—antiques, vacations, gourmet dinners, boat trips, ceramics, hand-crafts, baked goods and the raffle of a one hundred dollar bill donated by Dr. and Mrs. Ben Zola.

The auction itself began at 8:30 p.m., and according to Mrs. Karaffa, seats filled the Inn's first floor, with people "spilling onto" the terrace on what was an abnormally warm March evening. The bidding continued until midnight. "That everything worked so smoothly and successfully" said the chairman, "was due to my terrific committee and many, many weeks of work." What's that about action speaking louder than words? Well, here are the Licking county auxiliaries who sparked the action that produced the auction that netted seven thousand dollars: Mrs. Claudio Rousseau and Mrs. L. C. Thompson, reservations and printing; Mrs. Don Jones, invitations; Mrs. Robert Raker and Mrs. Leroy Bloomberg, donations; Mrs.

Pete Dils, crafts; Mrs. Michael Ratterman, publicity; Mrs. Michael Thorne, decorations; Mrs. A. S. Burton, telephone; Mrs. John Houser, baked goods and Mrs. Jay Eckhardt, silent auction.

There was excellent coverage of the event in the *Granville Sentinel* with a virtual full-page photographic display of the "Going, Going - - - SOLD." Our congratulations to the Licking County auxiliary for what certainly must come close to being an unprecedented one-night money-maker for a very, very good cause! Auxiliaries elsewhere, are you readin'???? (Read about Lorain county a bit farther on.)

### Medical Hypnosis

Want a "recipe" for a successful meeting? Take one very active auxiliary — in this case, Summit County — add an outstanding and very knowledgeable speaker (in this case, E. Gates Morgan, M.D., president of the Summit County Medical Society) — mix in an intriguing subject (like medical hypnosis) — and add a "touch of representation" (like from such organizations as the Cancer Society, Junior Women's Civic Club,

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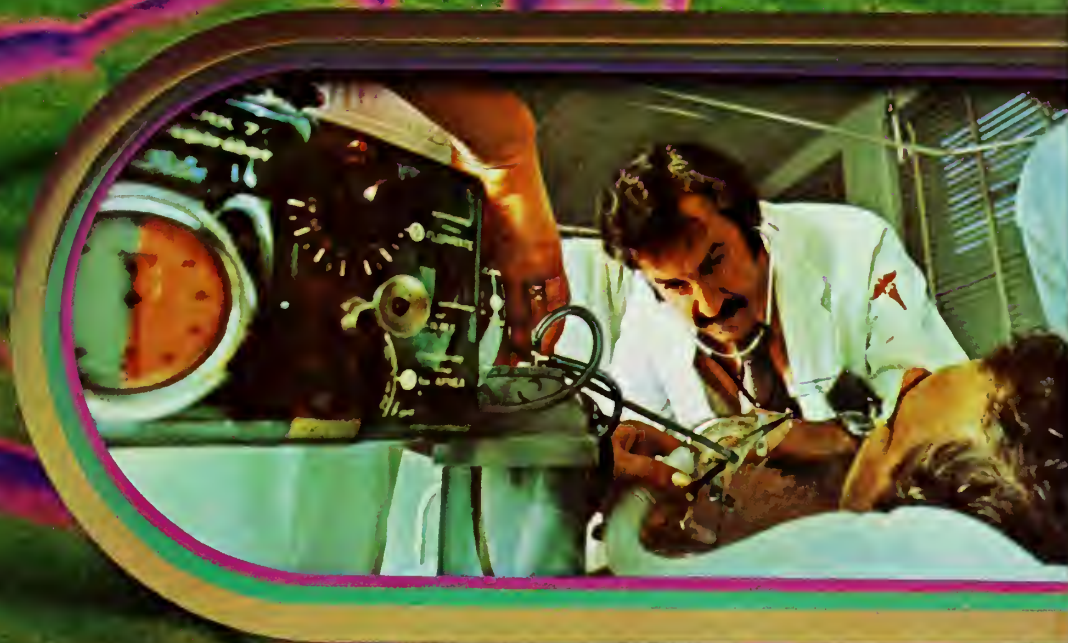
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# a major problem

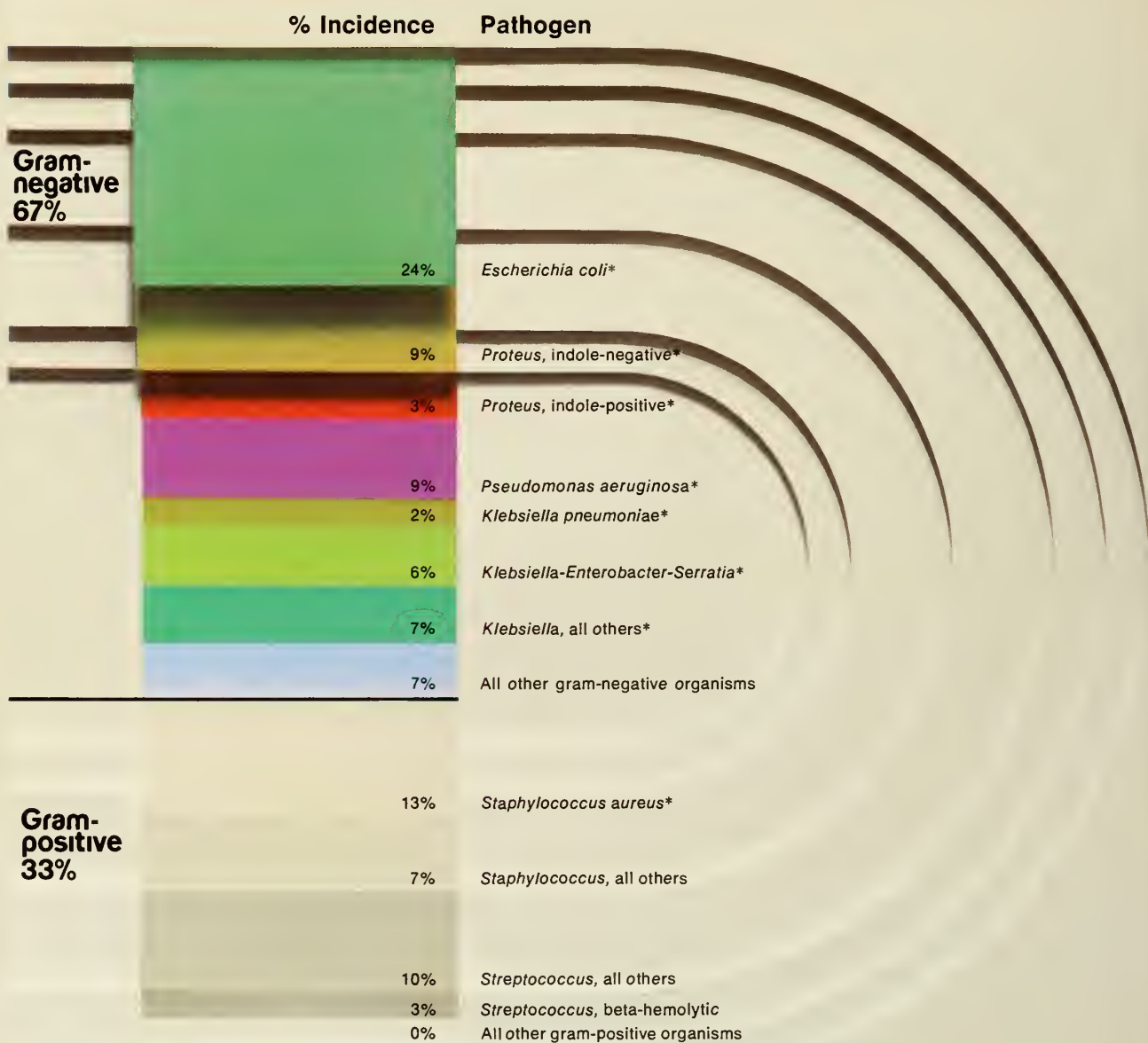
2 out of 3  
nosocomial infections  
are gram-negative



*Gram-negative bacteria magnified 10,000 times—color-tinted*



# Commonly encountered pathogens on all hospital services



Total pathogens 21,972  
Source: Gosselin Audit of Pathology Cultures—1971

\*GARAMYCIN Injectable is effective against susceptible strains of the pathogens indicated.



# A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high probability of effectiveness against susceptible strains of seven out of seven major gram-negative pathogens. These are:

*Escherichia coli*  
*Proteus*, indole-negative  
*Proteus*, indole-positive  
*Pseudomonas aeruginosa*  
*Klebsiella*  
*Enterobacter*  
*Serratia* } species

GARAMYCIN Injectable has also been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

## Start with Garamycin

### ■ Broad gram-negative spectrum

Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

## Stay with Garamycin

### ■ Susceptibility of causative organisms confirmed

The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

### ■ Relatively low incidence of adverse reactions

Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

### ■ Bacterial resistance has not been a problem

In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.



On all in-patient services...

**Garamycin<sup>®</sup>**  
**gentamicin**  
**sulfate** **injectable**  
**I.M./I.V.**

**40 mg. per cc.**

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

(serious gram-negative infections pneumonia, urinary tract infections, septicemia, and wound infections)\*

\*See text for susceptible organisms

## WARNING

Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments

or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

**USAGE IN PREGNANCY** Safety for use in pregnancy has not been established.

**On all in-patient services...  
in hospital-acquired gram-negative infections\***

# Garamycin®

## gentamicin sulfate

### Injectable

**I.M./I.V.**

**40 mg. per cc.**

Each cc. contains  
gentamicin sulfate equivalent  
to 40 mg. gentamicin

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**GARAMYCIN®** Injectable, brand of gentamicin sulfate U.S.P., injection, 40 mg./cc. Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin For Parenteral Administration

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**USAGE IN PREGNANCY** Safety for use in pregnancy has not been established.

**INDICATIONS** GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

**Pseudomonas aeruginosa**, **Proteus** species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

**CONTRAINDICATIONS** A history of hypersensitivity to gentamicin is a contraindication to its use.

**WARNINGS** See Warning Box.

**PRECAUTIONS** Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

#### ADVERSE REACTIONS

**Nephrotoxicity:** Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

**Neurotoxicity:** Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss. Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

**Note:** The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

**DOSAGE AND ADMINISTRATION** GARAMYCIN Injectable may be given intramuscularly or intravenously.

#### For Intramuscular Administration:

##### PATIENTS WITH NORMAL RENAL FUNCTION\*

**Adults:** The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the

usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

\*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

#### For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

**HOW SUPPLIED** GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972

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St. Thomas Hospital Women's Guild, Ohio Arts Council, Stark County Dental Auxiliary, Cerebral Palsy Women's Board, Reach to Recovery Program and the Women's Bar Auxiliary).

Summit County's February "special treat" was in the form of a luncheon at the Fairlawn Country Club. Dr. Morgan (whose lovely wife, Dolores, is auxiliary president) was introduced by Eddie Elias, prominent Akron business man and attorney (a continuing new idea of having a prominent local person introduce the principal speaker at auxiliary functions).

Along with Dr. Morgan's affiliations with many prestigious groups is his special affiliation as a Fellow of the American College of Medical Hypnotists and his membership with the American Society of Clinical Hypnosis and the International Institute of Hypnosis.

For an hour and a half, Dr. Morgan held his audience in complete interest and fascination and I am told he had no difficulty in getting four volunteers for his demonstration in medical hypnosis (including state president-elect, Mrs. Karl Ulicny). The talk preceding the demonstration dealt with the origin of hypnosis and its value, not only in the medical and dental fields, but in erasing fears and apprehensions from many sources. Later, Dr. Morgan was besieged with questions. "He very nearly had a seminar going," commented his wife.

Decorations chairman Wini Riddle and Helene Henault outdid themselves with fresh flowers flown in from Hawaii for the speakers' table, the individual tables and the special corsages. The centerpiece of each table was a cluster of baby orchids and each such centerpiece was then to be given to the "oldest lady at the table." Says Dolores Morgan, "the announcement produced a big laugh and a lot of blank memories . . . anyway, all orchids were gone when the last person left in spite of my prediction they would all still be there!"

Summit County has so many things going, I can't begin to cover them adequately in just one issue of *The Journal*. So, watch out for next month!

### Elsewhere in the State

Doctors' wives from five counties — Mahoning, Trumbull, Columbiana, Stark and Summit — numbering 115 — attended a day-long meeting of the state auxiliary's Sixth District at the Sheraton Inn in Youngstown recently. A morning coffee hour opened the program which was followed by an "idea workshop," and a talk by Dr. Jack Schreiber. There was a question and answer period following Dr. Schreiber's talk, and then a luncheon. A style show featured the after-luncheon period at which there was an informal modeling of vaca-

tion and summer fashions by Mrs. Patrick Cestone, Mrs. Ben Bonarigo and Mrs. W. F. Whittaker.

Honored guests included Mrs. Louis Loria, State President; Mrs. Karl Ulicny, President-Elect; Mrs. Henry Holden, state AMA-ERF chairman; Mrs. Karl Wieneke, 6th district director; the presidents of the five county auxiliaries: Mrs. C. E. Pichette, Mahoning; Mrs. Laszlo J. Bujdoso, Columbiana; Mrs. H. R. Hunt, Trumbull; Mrs. David Fitzelle, Stark; Mrs. E. Gates Morgan, Summit.

### Lorain donates \$2,500

The Lorain auxiliary realized \$2,541.95 from a Benefit Auction (another terrific activity!) held in December under the chairmanship of Mrs. Andrew V. Boysen. This money was then turned over to the Scholarship Fund of the Lorain County Medical Foundation for area students. The proceeds from the December auction bring the total amount contributed to the Foundation Scholarship Fund up to \$9,866 since 1968, when the first auction was initiated by the auxiliary. The articles donated for sale are usually handmade by the members and their husbands and range from ceramics, sweaters, afghans, paintings, sculpture, etc. to baked goods.

Governed by a ten-member Board of Supervisors comprised of laymen and physicians, the Foundation annually distributes scholarships to area students preparing for careers in medicine, nursing, pharmacy, therapy, technology and other para-medical fields which require specialized skills. It would seem that auctions are the "in thing" for accomplishing things! Congratulations to Lorain County and to its president, Mrs. John B. McCoy, of Elyria.

## OSU's 'Community Hospitals' Programs Accredited by AMA

Ohio State University College of Medicine recently received notification from the American Medical Association that the course material available from the University through the Computer Assisted Instruction Program, and presented in a number of community hospitals throughout Ohio, is allowable for credit for the AMA Continuing Education efforts.

The above information was reported to *The Journal* by William G. Pace, M.D., assistant dean and director of the Center for Continuing Medical Education at OSU.

For more information on the AMA's continuing medical education program, please refer to the Supplement to the *Journal of the AMA*, dated August 14, 1972.



## Certification of Death Is a Medical Decision, Profession Is Advised

Following is the text of a communication forwarded to *The Journal* by Myra C. F. Freet, R.N., Executive Secretary, Board of Nursing Education and Nurse Registration, State of Ohio.

"In certain health care settings, nurses are frequently asked to pronounce a patient dead. As a result of numerous inquiries from nurses and nursing organizations, and because the Ohio Revised Code does not specify who may make this judgment, the Ohio State Board of Nursing Education and Nurse Registration requested the Attorney General to render an Opinion on this issue.

"In Opinion No. 72 116, based on R.C. 3705.07, which states in part: 'The medical certificate of death shall be made and signed by the physician who attended the deceased or by the coroner within forty-eight hours after death. \* \* \*,' the Attorney General concluded that '\* \* \* this is a medical decision which can be made only by a qualified physician.'

"This interpretation by the Attorney General establishes the fact that the pronouncement of death is clearly outside the scope of practice of the registered professional nurse or the licensed practical nurse in Ohio.

"We would appreciate your sharing this information with the county medical societies and any other groups and individual physicians with whom you maintain communications."

## Sports Injury Symposium Scheduled in Warren

A Symposium on Sports Injury and Prevention is scheduled at the Warren YMCA, 210 High Street, N.W., Warren, on May 19. This program is being held for the benefit of faculty members involved in sports programs in the junior and senior high schools of Trumbull County and neighboring areas of Northeastern Ohio.

Dr. Joseph Logan and Dr. Ranulfo Grocilla, who are in charge of arrangements, have invited all persons in the Northeastern Ohio area who are interested in school sports programs. The faculty consists of team physicians, coaches and trainers; also an attorney who will discuss medical-legal aspects in sports. The program runs from 9:00 a.m. to 4:30 p.m.

For additional information, contact Mrs. Kay Ticknor, executive secretary, Trumbull County Medical Society, 280 N. Park Ave., Warren 44481.

### WHAT TO WRITE FOR

**Adaptations and Techniques for the Disabled Homemaker**—A 32-page pamphlet designed as an aid for occupational therapists, nurses, patients and families; price, \$1.75. This is one of numerous pamphlets on rehabilitation and visual aids available from the Sister Kenny Institute, 1800 Chicago Ave., Minneapolis, Minn. 55404.



Accredited by Joint Commission on Accreditation of Hospitals.

GUY H. WILLIAMS, Jr., M.D.  
Medical Director

G. PAULINE WELLS, R.N.  
Admin. Director

MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

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A NONPROFIT CORPORATION

— ESTABLISHED 1898 —

Chagrin Falls, Ohio

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**A hospital for the treatment  
of Psychiatric Disorders**

High on a Hill-Top, Overlooking Beautiful  
Chagrin River Valley.

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HERBERT A. SIHLER, Jr.  
President

# County Societies' Officers and Meeting Dates

ROSTER UPDATED THROUGH APRIL 15, 1973

## First District

Councilor: Stephen P. Hogg, Cincinnati 45219  
250 Wm. Howard Taft Rd.

ADAMS—Kenneth C. Jee, President, West Street, Winchester 45697; Hazel L. Sproull, Secretary, 113 East Mulberry St., West Union 45693; 1st Tuesday of Jan., Apr., July & Oct.

BROWN—John R. Donohoo, President, 111 Cherry St., Georgetown 45121; Antonio P. Mendoza, Secretary, 120 E. Plane St., Bethel 45106; 1st Sunday.

BUTLER—Mel N. Davis, President, 435 Park Ave., Hamilton 45013; Mr. E. Clifford Roberts, Executive Secretary, 111 Buckeye St., Hamilton 45011; 4th Wednesday.

CLERMONT—Raymond L. Davidson, President, 684 Batavia Pike, Cincinnati 45245; Carl A. Minning, Secretary, 2548 Williamsburg Pike, Batavia 45103; 3rd Wed. monthly except in July, Aug. & Dec.

CLINTON—Yong Jin Kim, President, 12 N. Lincoln, Wilmington 45177; Nathan S. Hale, Secretary, 586 W. Main St., Wilmington; 2nd Tuesday.

HAMILTON—Harold Schiro, President, 2650 Burnet Ave., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202; 2nd Tuesday, Sept., Nov., Jan., Feb., April, and May.

HIGHLAND—Walter Felson, Acting Secretary, 357 South St., Greenfield 45123.

WARREN—Gary P. Hayes, President, 109 Oregonia Rd., Lebanon 45036; Howard Berninger, Secretary, 109 Oregonia Rd., Lebanon 45036; 2nd Tuesday.

## Second District

Councilor: James G. Tye, Dayton 45402  
I.B.M. Building Suite 520

CHAMPAIGN—Terrence Grogan, President, 848 Scioto St., Urbana 43078; John Flora, Secretary, 848 Scioto St., Urbana 43078; 2nd Wednesday.

CLARK—John F. Harley, President, 444 W. Harding Road, Springfield 45504; Mrs. Fonda Geer, Executive Secretary, 616 Bldg., Room 131, 616 N. Limestone St., Springfield 45503; 3rd Monday except June, July, Aug. & Dec.

DARKE—Alvan E. Thuma, President, Arcanum Medical Center, Arcanum 45304; Peter H. Mulder, Secretary, Arcanum Medical Center, Arcanum 45304; 3rd Tuesday.

GREENE—Felix Garfunkel, President, Greene Memorial Hosp., Xenia 45385; Mrs. Clyde (Virginia) Jones, Executive Secretary, 1003 Farnell Dr., Xenia 45385; 3rd Friday.

MIAMI—Robert Price, President, 760 N. Westedge Dr., Tipp City 45371; A. Robert Davies, Secretary, 57 Robinhood Lane, Troy 45373; 1st Tuesday.

MONTGOMERY—Robert L. Taylor, President, 111 W. First St., Dayton 45402; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Bldg., Dayton 45402; Monthly as established by Executive Council.

PREBLE—J. D. Darrow, President, 228 N. Barron St., Eaton 45320; J. R. Williams, Secretary, 228 N. Barron St., Eaton 45320; No regular meeting date.

SHELBY—George J. Schroer, President, 20 S. Main St., Fort Loramie 45845; William F. Mentges, Secretary, 870 S. Main Ave., Sidney 45365; 3rd Tuesday, March, June, Sept., and Dec.

## Third District

Councilor: John C. Smithson, Findlay 45840  
521 W. Sandusky St.

ALLEN—G. E. Wright, President, 2551 W. Elm St., Lima 45805; Mr. Waldo Smith, Executive Secretary, Box 803, Lima 45801; 3rd Tuesday.

AUGLAIZE—Dale Kile, President, 112 Court St., St. Marys 45885; Charles Stienecker, Secretary, 1007 W. Auglaize St., Wapakoneta 45895; 1st Thursday every odd month, starting with January.

CRAWFORD—Theodore D. Sawyer, President, Family Medical Center, Crestline 44827; H. Morton Brooks, Secretary, Family Medical Center, Crestline 44827; called meetings.

HANCOCK—Manuel Sarmina, President, Blanchard Valley Hosp., Findlay 45840; Truman S. Smith, Secretary, 145 N. Wallace St., Findlay 45840; 3rd Tuesday except July and Aug.

HARDIN—Jose Guzman, President, 538 N. Detroit St., Kenton 43326; Larry E. Clark, Secretary, 216 E. Franklin St., Kenton 43326.

LOGAN—Harry L. Graber, President, Route 2, West Liberty 43357; David R. Miller, Secretary, Mary Rutan Hospital, Bellefontaine 43311; 4th Thursday.

MARION—Brooks H. Sitterley, President, Marion General Hosp., Marion 43302; William H. Whitehead, Secretary, 1025 Harding Memorial Pkwy; 1st Tuesday except Feb., June, July, Aug. and Oct.

MERCER—Louis J. Finkelmeier, President, 111 N. Walnut, Celina 45822; R. Duane Bradrick, Secretary, Box 145, Rockford 45882; 3rd Thursday.

SENECA—Emmet T. Sheeran, President, 430 Elm St., Fostoria 44830; Mohammad Anvari-Hamedani, Secretary, 1316 W. Ridge Dr., Fostoria 44830.

VAN WERT—H. D. Underwood, President, Medical Arts Bldg., Fox Rd., Van Wert 45891; Wilmer Iler, Secretary, Medical Arts Bldg., Fox Rd., Van Wert 45891; 1st of month.

WYANDOT—N. J. Zohoury, President, 132 E. Wyandot Ave., Upper Sandusky 43351; Herschel N. Rhodes, Secretary, 777 N. Sandusky Ave., Upper Sandusky 43351; 2nd Tuesday.



## County Society Roster (continued)

### Fourth District

Councilor: George N. Bates, Toledo 43624  
316 Michigan St.

DEFIANCE—Ben B. Lenhart, President, 1075 E. Second St., Defiance 43512; Mrs. Pauline Boroff, Executive Secretary, 1206 E. Second St., Defiance 43512; Quarterly.

FULTON—Richard L. Davis, President, 137 S. Fulton St., Wauseon 43567; Gerald A. Perkins, Secretary, R.R. #1, Box 20-A, Delta 43515; Quarterly.

HENRY—T. F. Moriarty, President, 651 Strong St., Napoleon 43545; K. E. Dye, Secretary, East St., Liberty Center 43532.

LUCAS—Roland A. Gandy, Jr., President, 2345 Auburn Ave., Toledo 43606; Mr. Lee F. Wealton, Executive Director, 3101 Collingwood Ave., Toledo 43610; 4th Tuesday except July and Aug.

OTTAWA—Dietrich W. Felber, President, 730 Jefferson St., Port Clinton 43452; John F. Bodie, Secretary, 1130 Lee Avenue, Port Clinton 43452; 1st Monday.

PAULDING—Don K. Snyder, President, Rt. 2, Box 9, Payne 45879; Kirkwood A. Pritchard, Secretary, 119 S. Main, Paulding 45879; 3rd Monday.

PUTNAM—Charles B. Kidd, President, Kalida 45843; Oliver N. Lugibihl, Secretary, Pandora 45817; 1st Tuesday.

SANDUSKY—Robert J. Gedert, President, 1314 Hayes Avenue, Fremont 43420; Mrs. Patsy Askins, Executive Secretary, Memorial Hospital, Fremont 43420; Quarterly.

WILLIAMS—Lenin Rivera-Nieves, President, 307 1st St., Pioneer 43554; George J. David, Secretary, P.O. Box 337, Edon 43518; 3rd Tuesday.

WOOD—Vytautas V. Urba, President, 1010 N. Prospect St., Bowling Green 43402; Restituto H. Alonzo, Secretary, 725 Haskins Rd., Bowling Green 43402; 3rd Thursday.

### Fifth District

Councilor: David Fishman, Cleveland 44104  
11201 Shaker Blvd.

ASHTABULA—R. W. Shelby, President, 524 West 24th, Ashtabula 44004; Mrs. Marilyn Mathews, Executive Secretary, P.O. Box 1772, Ashtabula 44004; 2nd Tuesday.

CUYAHOGA—Julius Wolkin, President, 11811 Shaker Blvd., Cleveland 44120; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 44106; 2nd Tuesday.

GEAUGA—Vartkes Majarian, President, Medical Arts Bldg., Rt. 6, Chardon 44024; Mrs. Martha Withrow, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024; 2nd Thursday.

LAKE—W. L. Irwin, President, 36001 Euclid Ave., Willoughby 44094; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060; 4th Wednesday evening of Jan., March, May, Sept., and Nov.

### Sixth District

Councilor: Maurice F. Lieber, Canton 44703  
515 Third St. N.W.

COLUMBIANA—Frank V. Apicella, President, 1348 N. Union Ave., Salem 44460; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460; 3rd Tuesday.

MAHONING—C. Edward Pichette, President, 1019 Boardman-Canfield Rd., Youngstown 44512; Mr. Howard Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504; 3rd Tuesday of Jan., March, May, Sept., Nov., and Dec.

PORTAGE—Amador P. Rasalan, President, 500 S. DePeyster St., Kent 44240; A. A. Kuri, Secretary, 250 S. Chestnut St., Ravenna 44266; 3rd Tuesday.

STARK—Robert Gardner, President, 515 Third St., N.W., Canton 44703; Mr. John H. Austin, Executive Secretary, 405 4th St., N.W., Canton 44702; 2nd Thursday, except May thru Sept.

SUMMIT—R. H. Champion, President, 513 West Market St., Akron 44303; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant St., Akron 44311; 2nd Tuesday.

TRUMBULL—Joseph Sudimack, Jr., President, 121 Center St., West, Warren 44481; Mrs. Kay Ticknor, Executive Secretary, 280 N. Park Ave., Warren 44481; 3rd Wednesday, Sept. through May.

### Seventh District

Councilor: Robert E. Rinderknecht, Dover 44622  
404 N. Walnut St.

BELMONT—Luis A. Vasquez, President, 179 W. Main St., St. Clairsville 43950; Mr. Tom Gilot, Executive Secretary, Clark Rd., St. Clairsville 43950. 3rd Thursday, Feb., Mar., Apr., June, Sept., Oct., Nov., and Dec.

CARROLL—Jack L. Maffett, President, 264 S. Lisbon St., Carrollton 44615; Robert H. Hines, Secretary, 625 N. Market, Minerva; 3rd Tuesday.

COSHOCTON—Tae. K. Park, President, 1325 Chestnut, Coshocton 43812; W. R. Agricola, Secretary, 232 Cross St., Newcomerstown 43832; 2nd Tuesday, except June, July, Aug.

HARRISON—Gerald E. Vorhies, President, Scio 43988; James Z. Scott, Secretary, Box 512, Scio 43988; Quarterly.

JEFFERSON—James V. Current, President, 114 Brady Circle E., Steubenville 43952; Mrs. Joseph (Mary) Freedman, Corresponding Secretary, P.O. Box 655, Steubenville 43952; 1st Tuesday.

MONROE—Byron Gillespie, Secretary, 158 South Main, Woodsfield 43793.

TUSCARAWAS—J. J. Houglan, President, 1810 N. Wooster Ave., Dover 44622; D. R. Kollman, Secretary, Box 341, Tuscarawas 44682; 3rd Wednesday.

### Eighth District

Councilor: William M. Wells, Newark 43055  
241 Hudson Street

ATHENS—Leland Randles, President, Hudson Health Center, Athens 45701; L. A. Hamilton, Secretary, 400 East State, Athens 45701; 2nd Tuesday, Mar., June, Sept., Dec.



## County Society Roster (continued)

**FAIRFIELD**—David C. Lifer, President, 214 Harmon Ave., Lancaster 43130; David H. Sheidler, Secretary, 1500 E. Main St., Lancaster 43130; 2nd Tuesday.

**GUERNSEY**—Miroslaw W. Hnatiuk, President, Seneca-ville 43780; Robert O. Thiele, Secretary, Box 37, Bylesville 43723; 1st Tuesday.

**LICKING**—Robert F. Sylvester, Jr., President, 843 North 21 Street, Newark 43055; Alfred Jay Eckhardt, Secretary, 1272 West Main St., Newark 43055; 4th Tuesday, except June, July, Aug.

**MORGAN**—A. H. Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, 426 E. Union Ave., McConnelsville 43756.

**MUSKINGUM**—Myron H. Powelson, President, 2825 Maple, Zanesville 43705; Hudnall J. Lewis, Secretary, 208 E. Highland St., Zanesville 43701.

**NOBLE**—Frederick M. Cox, President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, Secretary, P.O. Box 239, Caldwell 43724; 1st Tuesday.

**PERRY**—Sydney N. Lord, President, E. Main St., Somerset 43783; Charles E. Bope, Secretary, W. Main St., Somerset 43783.

**WASHINGTON**—Leopoldo H. Banuelos, President, Marietta Memorial Hosp., Marietta 45750; L. Eugene Plummer, Secretary, 215 Marion St., Marietta 45750; 2nd Wednesday, except June, July, Aug.

### Ninth District

Councilor: Thomas W. Morgan, Gallipolis 45631  
1st Ave. and Cedar St.

**GALLIA**—John F. Groth, Jr., President, Holzer Medical Center Clinic, Gallipolis 45631; Donald M. Thaler, Secretary, Holzer Medical Center Clinic, Gallipolis 45631; 3rd Thursday, Jan. and Oct.

**HOCKING**—John W. Doering, Acting Secretary, 42 N. Spring, Logan 43138.

**JACKSON**—Earl J. Levine, President, 120 N. Ohio Ave., Wellson 45692; Carl J. Greever, Secretary, 35 Vaughn St., Jackson 45640.

**LAWRENCE**—A. Burton Payne, Vice-President, 411 Center St., Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth St., Ironton 45638; Quarterly.

**MEIGS**—Edmund Butrimas, President, 204 E. Main St., Pomeroy 45469; Joseph J. Davis, Secretary, 306 N. Second Ave., Middleport 45760.

**PIKE**—W. W. Wiltberger, President, 330 E. North St., Waverly 45690; Albert Shrader, Secretary, 196 Emmitt St., Waverly 45690; 1st Tuesday.

**SCIOTO**—L. R. Chaboudy, President, 1725 27th St., Portsmouth 45662; Mr. Lowell E. Thompson, Executive Secretary, Scioto County Medical Society, P.O. Box 1348, Portsmouth 45662; 2nd Tuesday.

**VINTON**—

### Tenth District

Councilor: James C. McLarnan, Mt. Vernon 43050  
104 E. Gambier St.

**DELAWARE**—Mary K. Kuhn, President, 101 E. High St., Ashley 43003; Lloyd E. Moore, Secretary, Magnetic Springs 43036; 3rd Tuesday, except June, July, Aug.

**FAYETTE**—R. U. Anderson, President, 114 N. North St., Washington C.H. 43160; M. H. Roszmann, Secretary, 1005 E. Temple, Washington C.H. 43160; 2nd Friday.

**FRANKLIN**—Ben Arnoff, President, 4713 N. High St., Columbus 43214; Mr. W. "Bill" Webb, Executive Secretary, 17 South High St., Suite 528, Columbus 43215; 3rd Tuesday, Jan., March, Oct.

**KNOX**—Robert Westerheide, President, 812 Coshocton Ave., Mt. Vernon 43050; Henry T. Lapp, Secretary, Medical Arts Bldg., Mt. Vernon 43050; 1st Wednesday.

**MADISON**—William C. Locke, President, 61 E. High St., London 43140; John Sullivan, Secretary, 10082 Col. Cinn. Rd., South Charleston 45368; Quarterly.

**MORROW**—William S. Deffinger, President, State Rt. 229W, Marengo 43334; David James Hickson, Secretary, 88 E. High St., Mt. Gilead 43338.

**PICKAWAY**—Robert G. Smith, President, 214 E. Franklin St., Circleville 43113; F. W. Anderson, Secretary, 630 Northridge Road, Circleville 43113; 2nd Tuesday.

**ROSS**—J. C. Berno, President, 85 W. 2nd St., Chillicothe 45601; Wm. J. Corzine, Secretary, 217 Delano, Chillicothe 45601; 1st Thursday.

**UNION**—H. E. Stricker, President, 247 W. 5th St., Marysville 43040; May B. Zaugg, Secretary, Rt. #5, Timber Trails, Marysville 43040; 1st Tuesday, Feb., Apr., Oct., Dec.

### Eleventh District

Councilor: Robert G. Thomas, Elyria 44035  
630 River Street

**ASHLAND**—Jon Cooperrider, President, 637 N. Union, Loudonville 44842; Charles Warne, Secretary, 350 Hillcrest Dr., Ashland 44805; 1st Thursday.

**ERIE**—Robert D. Gillette, President, P.O. Box 127, Huron 44839; Mrs. Barbara Wolfert, Executive Secretary, 1428 Hollyrood Rd., Sandusky 44870. 2nd Tuesday, except July and Aug.

**HOLMES**—William Powell, President, W. Adams, Millersburg 44654; Paul Roth, Secretary, N. Main St., Killbuck 44637; 3rd Monday.

**HURON**—Richard L. Jackson, President, 388 E. Howard St., Willard 44890; Shan A. Mohammed, Secretary, 3 Milan Manor Drive, Milan 44846; 2nd Wednesday.

**LORAIN**—John B. McCoy, President, 1036 Gulf Road, Elyria 44035; Mrs. Gladys Davidson, Executive Secretary, 1480 North Ridge Rd. E., Elyria 44035. 2nd Tuesday, except June, July and Aug.

**MEDINA**—Hilaire Gaudreault, President, 2546 Center Rd., Hinckley 44233; Mr. A. Dana Whipple, Executive Secretary, 943 N. Jefferson St., Medina 44256. 3rd Thursday.

**RICHLAND**—James W. Wiggin, President, 151 Marion Ave., Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield, 44903. 3rd Thursday.

**WAYNE**—Viola Startzman, President, Hygeia Hall, College of Wooster, Wooster 44691; Thomas M. Graves, Secretary, 1740 Cleveland Road, Wooster 44691; 2nd Wednesday, alternate months.

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17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

OHIO, FAIRFIELD. Space available in modern Medical Building, 15 miles from Cincinnati. General Practitioner and Specialist needed. Reply to Box 616, c/o The Ohio State Medical Journal.

GROUP FAMILY PRACTICE—Excellent opportunity for family practice in pleasant, progressive town near Columbus, Ohio. No OB; well-equipped medical center, 5200 sq. ft., including twelve examining rooms, small surgery, own laboratory and x-ray; three GPs already in practice; part-time coverage of college health service; modern well-equipped 350-bed community hospital with active consulting service and ER group 4 miles from office; excellent local schools. Salary plus percentage first year. Write to Granville Medical Center, Inc., Granville, Ohio 43023.

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DIRECTOR OF FAMILY PRACTICE PROGRAM: The search committee of the Family Practice Residency Committee of the Toledo Hospital, Toledo, Ohio 43606, is prepared to interview interested physicians for a full-time position in a new Family Practice Residency Program to begin about September 1, 1973. For information or an appointment for interview please contact: Henry R. Silverman, M.D. 4352 Sylvania Avenue, Toledo, Ohio 43623. Telephone: 419/882-7165.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

OHIO, AKRON: Exciting opportunity for psychiatrist interested in taking over an out-patient private practice. Net income \$40,000 and up. Consultation to local agencies, hospital privileges, teaching also available. Contact Box 670 c/o Ohio State Medical Journal.

VACATION CONDOMINIUM — New Smyrna Beach, Fla. — just south of Daytona and away from the crowds, but enjoying the same beautiful beach. Two bedrooms, 2 baths, wall-to-wall carpeting, completely and tastefully furnished including linens, color TV and dishwasher, HEATED POOL, and sauna. \$400 per month. For reservations or further information, contact Wm. W. Conner, M.D., 517 Lakeshore Dr., Eustis, Florida 32726. Phone 904-357-5715.

FOR RENT OR LEASE—General Practitioner's Office for 10 years. Suite of 4 rooms—central air-conditioned—carpeted—paneled. Parking in rear. Phone: 614/224-6972 or 614/231-1987. Columbus, Ohio.

WANTED: LOCUM TENENS for E.R. for 1-2-3 months in July, August or September. \$3,000 plus my own house per month. Opportunity to join group as fifth man is open! Contact: B. Sarihan, M.D., 2501 Marinette Dr., Springfield, Ohio. 45503, Tel: 513-399-7828.

FAMILY PRACTICE RESIDENCY — Just approved — openings at all levels — can start immediately — for details contact: A. J. Pultz, M.D., Chairman, Family Practice Committee, Grant Hospital, 309 E. State, Columbus, Ohio 43215.

UNIVERSITY HEALTH SERVICE—Ohio—Excellent opportunity to join compatible staff in well equipped modern facility; liberal vacation and time off with many other fringe benefits; salary negotiable. Contact: Henry Vogtsberger, M.D., Student Medical Center, Bowling Green State University, Bowling Green, Ohio 43403. An Equal Opportunity Employer.

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**HOUSE PHYSICIANS MEDICAL AND SURGICAL ECFMG CERTIFICATE REQUIRED.** Board eligibility desirable. Salary commensurate with training and experience. Fringe benefits include paid hospitalization, uniforms, meals, and malpractice insurance. Contact: Dept. of Medical Education, Lakewood Hospital, 14519 Detroit Road, Lakewood, Ohio 44107.

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**CRITICAL CARE SPECIALISTS (INTENSIVISTS)**—New program developed providing 24-hour inpatient care. 400 bed general hospital with 10-bed ICU and 11-bed CCU; Cardiac Cath Lab, open heart and vascular surgery. Especially need full-time director ICU, and full-time director CCU. New facilities. Ohio license or reciprocity. Salary competitive. Inquiries to: Medical Care Foundation of Lakewood, 14519 Detroit Ave., Lakewood, Ohio 44107.

**OB-GYN WANTED** to associate with well-established, busy 38-year-old Junior Fellow doing over 500 deliveries/year in Portsmouth, Ohio. Share work and income from first day. Two modern fully approved hospitals in this pleasant Ohio University Branch College town. Please contact: John S. Temponeras, M.D., 3350 Indian Drive, Portsmouth, Ohio 45662. Tel. 614/354-2616 or 614/353-6220.

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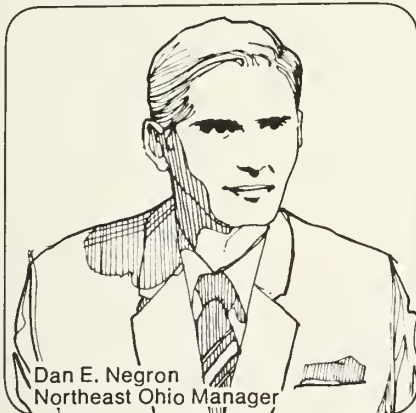
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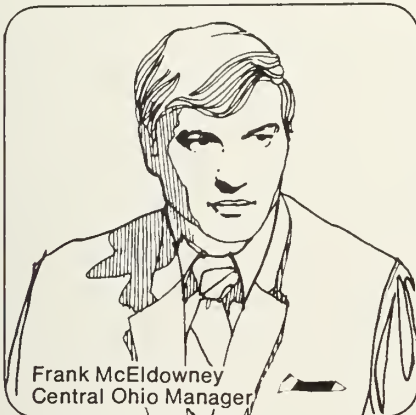
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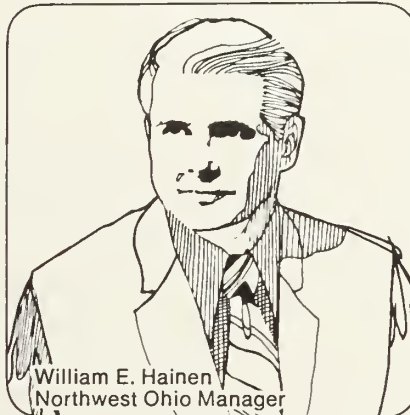
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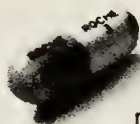
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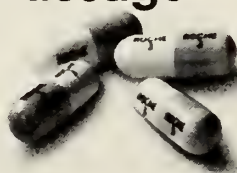
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**Contraindications:** Patients with known hypersensitivity to the drug.

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**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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JUNE • 1973  
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# *The Ohio State* **MEDICAL JOURNAL**

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

18 JUN 1973

## **In This Issue**

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Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

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**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# Physicians, Future Shock And The AMA

By RAYMOND T. HOLDEN, M.D., Member, AMA Board of Trustees

"The AMA doesn't represent me."

That line—a top candidate for the most-abused-cliche-of-the-year award—is an excellent place, I believe, to begin a discussion of the relationship between the American Medical Association and physicians.

It is an excellent place to begin because it summarizes a basic attitude expressed by most nonmembers and some currently disgruntled members of the AMA. And it points up what I believe to be an inherent fallacy about that relationship—a fallacy born of misunderstanding of what the AMA really is.

For that statement, while undoubtedly true in many instances, is not valid. No organization of national scope represents the views of each of its members at all times—nor should it be expected to. That is an unreasonable expectation on the face of it. Yet many physicians seem to demand just that of the AMA.

But there is an even more serious defect in such an argument. For while the AMA does offer the individual physician certain benefits relating to his personal and professional life, that is not the reason it exists.

The American Medical Association exists and functions, not to serve the particular interests of the individual physician, but to serve and represent the general interests of the profession.

How is this service and representation to be defined? How are these objectives to be achieved? What do they mean in terms of the relationship between the AMA and the physician, the government, the public?

The AMA is asking itself those very questions right now. And the answers are in a process of redefinition, for the AMA is undergoing a period of quiet, structured, evolutionary change. It is responding to the clearly evident need to become more representative of both its membership and of the medical profession at large.

Although this process of redefinition and change is not yet complete, some clear indications have emerged which make it possible to address with confidence the questions raised above.

As I stated earlier, it is not possible for the AMA to represent each individual physician. But it is possible—and desirable—for the AMA to represent each physician as a member of the medical profession as a whole.

This can be accomplished through what C. A. Hoffman, M.D., president of the AMA, termed in his inaugural address a "representative consensus" of the profession. To achieve this requires contributions from the broadest possible spectrum of the profession: from individuals, groups and organizations.

## Specialty Groups

Because it is aware of this, the AMA has taken steps and established procedures to broaden the franchise. By action of the House of Delegates, house staff physicians now elect a voting member to the House and the same right is about to be extended to medical students.

A total of 24 specialty groups now have special sections in the AMA and voting representation in the House of Delegates.

Both of these mechanisms provide opportunity for a physician to be represented within the context of his own special interest within the profession.

Through the original basic structure of the AMA, the state and local societies, a member has available to him a second mechanism for representation on a geographical basis.

Some physicians feel that neither of these mechanisms work in a manner deemed to insure true representation. Whatever the validity of this criticism, it needs only to be observed that it is subject to change. California, for one has moved to provide for direct election of delegates to the AMA House of Delegates, rather than their election by the California House of Delegates. Other states are considering similar action.

Such decisions are up to physicians to determine through the local and state societies. The AMA imposes neither the conditions of representation nor of membership.

The point is this: As a true federation, much of the effective power of the AMA is at the local



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**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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level. It is there to be used by the physician who is willing to pay the price of becoming involved. After that, it depends on his powers of persuasion and leadership as to how effective he will be.

Although its structure should insure true representation of its members' interests, the AMA within the past year has opened two direct lines of communication to its members at the local level. One was a membership opinion poll, sent to every member of the AMA. The second is the series of hearings being conducted by the Committee on Long Range Planning and Development.

Recommendations based on these hearings will be made to the House of Delegates at the Annual Convention in New York next June. The opinion poll drew response from over 50 percent of the membership and clearly established one basic fact: the AMA does indeed act in accordance with the general will of its membership and therefore does reflect the prevailing attitudes within the profession on various issues.

Yet if this is so, why then the general unease that pervades the profession which so often expresses itself in discontent with the AMA? Why the turn toward unionism and other forms of representation that only serve to undercut the efforts of the AMA and fragment the profession?

### Third-Party Payers

The answer, I think, lies in that phenomenon known as "future shock."

Both our nation and our profession are undergoing a period of growth and change that, while similar to other such periods in history in some respects, is unique in certain other respects. In this case, new knowledge and new technology are being created at a rate undreamed of only 20 years

ago. When these are linked to an instant communications system, the impact on both the individual and the society is coupled and redoubled.

"Future shock" for the practicing physician is compounded by the specter of some new form of government intervention into medical and health care—an intervention that would profoundly change the personal and professional life of every physician in the nation. The very vagueness of the nature of the intervention only serves to enhance the insecurity and doubt that such a threat inspires. And the experience of the medical profession with government programs and third-party payers has hardly been such as to inspire confidence.

Here we come, I believe, to the heart of the problem—the essential reason for disenchantment with the AMA on the part of some segments of the practicing profession. And again, this feeling derives in some part from a misunderstanding of the AMA, its structure and its policies.

What is the relationship of the AMA to the third-party payers and to the government?

Third-party payers operate essentially through local and regional programs. The AMA, as a federation, considers that the proper and logical approach is to permit its local and state societies to work out their own relationships with the local plans, supplying such support and information as is necessary. And on the national level, the AMA has representation on the board of Blue Shield through which it seeks to resolve any problems that can only be approached on that level.

Yet, it is only realistic to recognize that third-party payers are separate entities with interests and goals of their own which will not always coincide with those of the physician. The relationship,

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from our point of view, will probably never be perfect, but it can be improved and at least some of the frustration eliminated.

### No Compulsion

And the AMA can—and will—insure that third-party payers will not dictate the method or manner of medical practice.

We need to be equally realistic in our attitudes toward the government. We must recognize that we have passed the day when the private sector can answer all needs and resolve all problems. It simply does not have the resources.

But the private sector does have the talent and the knowledge—given the financial resources. And this fact forms the basis of the AMA's position toward government.

The AMA believes that, where necessary, the government should provide the resources to initiate or support programs or facilities but that operations should be left to the private sector. Further, there should be no element of compulsion in any government program nor should the government seek to dictate the practice of medicine or the terms of medical education.

In an increasingly large and complex society, government may be expected to seek a correspondingly larger role. This is inevitable. Also inevitable, however, is the basic acquisitive nature of government—any government.

And this is one of the very reasons why a strong, vigilant AMA is more necessary today than ever before. As government grows larger (and it will do so no matter what we wish), it is imperative in the interest of the freedom and vitality of the society, that there exist strong institutions outside of government to check its power, restrain its acquisitiveness and monitor its performance.

The individual citizen cannot do this. Small organizations cannot do it effectively. It requires a strong national organization with the strength that derives from a united membership to perform this task.

### Established Institutions

The impact of "future shock" is undermining faith in the American Medical Association just at the time when its continued existence is most necessary. This, too, I think is inevitable in light of the questioning and doubt and disorientation that accompanies any period of change.

But it is necessary to examine the consequences of such a trend. Nearly every factor in the present-day practice of medicine tends to accent the essentially disparate nature of our profession. New knowledge and technology, experimentation with new modes of practice—these and other factors emphasize specialization and division. Frag-

mentation in the method of representation will only accelerate these trends, not resolve them or the problems they create.

We need to recognize that in a time of change established institutions are at their most vulnerable yet, paradoxically, it is precisely at such times that they are most necessary.

For in a time of change and a time of questioning, established institutions offer a point of stability and a frame of reference. They serve as a base for rational transition, as the means for assimilating and effectuating new knowledge, as the guarantor of relevance, and specifically in the case of medicine, as the focal point for unity in an increasingly specialized and disparate profession.

If the profession is to pass through this period in an orderly fashion and maintain its integrity (a quality composed of many parts), these responsibilities must be performed by some organization.

The only organization that we as a profession possess that can play this role is the AMA.

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**Cleveland 216/243-6410**

**!See Page 427!**





Following are names of new members of the Ohio State Medical Association certified to the headquarters office during April. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ALLEN (Lima)  
Cheung S. Shin  
Mostafa Noori  
David Braun Steiner

AUGLAIZE  
Yeong-Cheol Koh,  
St. Marys

BELMONT  
Ki-Yong Sohn  
Bellaire  
Yung-Chun Tsai  
Bellaire

COLUMBIANA  
Romulo G. Morales  
Salineville

CUYAHOGA (Cleveland,  
except as noted)  
Felix Arakaki  
Carl F. Asseff  
Juanito V. Cua  
Victor J. DeMarco  
Earl J. Fleegler  
Saul M. Genuth  
Allan R. Goldstein  
Arnold H. Greenhouse  
Frank H. Hendricks, Jr.  
Arun Jayavant  
Mario C. Leguizamon  
Sutek Lie  
Rosemary Lindan  
William Mourad  
North Olmsted  
Fabio Ochoa

## CUYAHOGA (Contd.)

Bienvenido D. Ortega  
Grace M. Paul  
Modesto M. Peralta, Jr.  
Howard J. Schwartz  
Ali N. Shaikh  
Candida G. Sicre  
Ben-Brigido Supnet  
Irwin T. Wason

DARKE  
Mahmood Mir  
Greenville

FRANKLIN (Columbus)  
L. Eugene Arnold  
Marcianito A. Bautista  
Stephen M. Berger  
David S. Brandt  
Soon P. Chang  
Rolando C. Congbalay  
Leopoldo L. Enrile, Jr.  
David R. Kelly  
John E. Leach  
Daniel J. Martin  
Richard S. Materson  
Watson D. Parker, Jr.  
Paul C. Redmond  
Augusto A. Santos  
John R. Schwarzell  
Raman Shanker  
Robert A. Wainer

HURON  
F. Frank Bordbar  
Norwalk

LOGAN  
David R. Miller  
Bellefontaine  
Koo-Hyun Moon  
Bellefontaine

LUCAS  
Mary Ellen Clifford  
Toledo  
Abraham Y. Sim  
Toledo

MAHONING  
(Youngstown)  
Norma J. Hazelbaker  
Chander M. Kohli  
Milton L. Paige  
Nicholas A. Pappas  
V. G. Raghavan  
Y. Peter Sheen  
Ramiro Albarran Sotelo

MONTGOMERY  
(Dayton)  
Jeremias A. Andrews  
Julius M. Matin  
V. Muthiah

RICHLAND  
John L. Marquardt  
Mansfield

ROSS  
Catherine T. Su  
Chillicothe

SCIOTO  
Hang S. Lee  
Portsmouth

SUMMIT (Akron except as  
noted)  
Akbar Dariushnia  
Maurice N. Johnson  
Harvey J. Weil  
Henry T. Wong  
Tallmadge

TRUMBULL (Warren  
except as noted)  
B. N. Subbarao  
Newton Falls  
Oscar F. Sterle  
Gil C. Rah  
Joseph E. T. Kavanagh  
Ahmet T. Cabi

WILLIAMS  
Gary E. Demuth  
Montpelier

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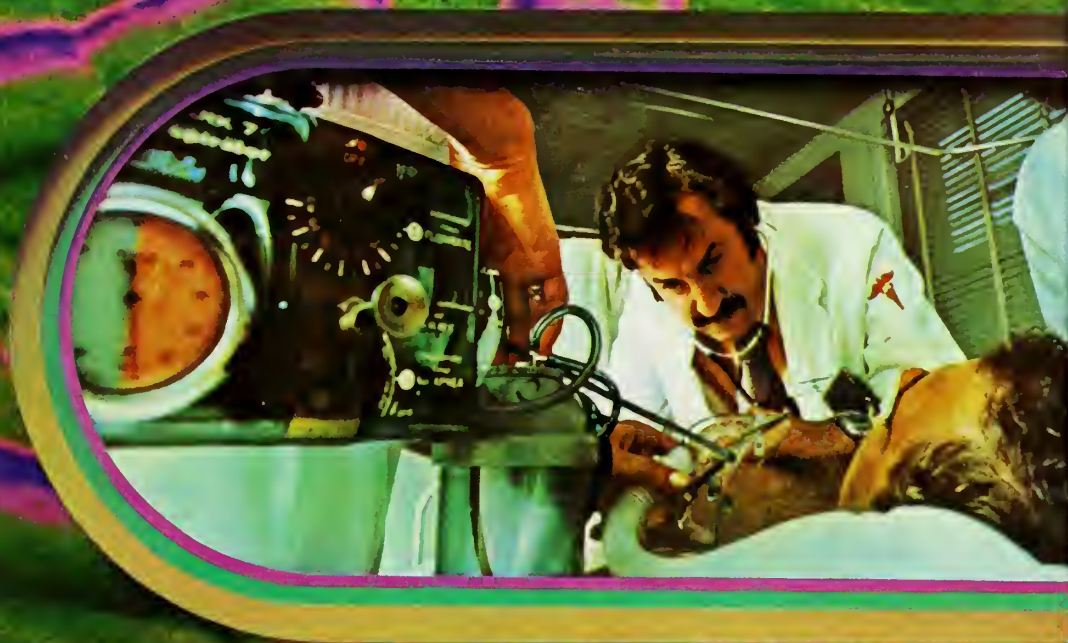
TWELFTH FLOOR 17 SOUTH HIGH STREET  
COLUMBUS, OHIO 43215 PHONE (614) 228-6115

Schering

On all in-patient  
services...

# a major problem

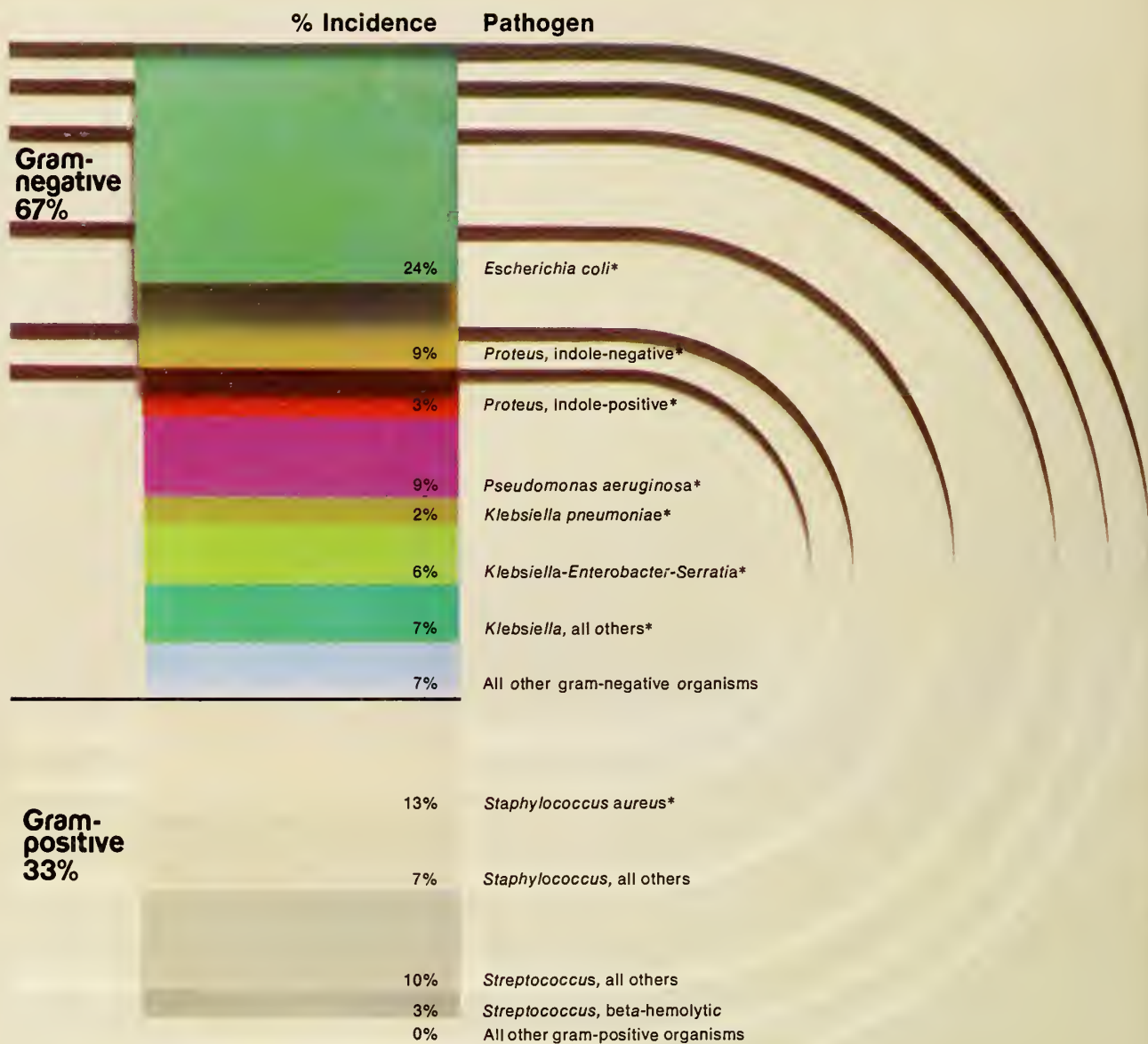
2 out of 3  
nosocomial infections  
are gram-negative



Gram-negative bacteria magnified 10,000 times—color-tinted



# Commonly encountered pathogens on all hospital services



Total pathogens 21,972  
Source: Gosselin Audit of Pathology Cultures—1971

\*GARAMYCIN Injectable is effective against susceptible strains of the pathogens indicated.



# A highly appropriate spectrum for today's problem pathogens

GARAMYCIN Injectable offers a high probability of effectiveness against susceptible strains of seven out of seven major gram-negative pathogens. These are:

*Escherichia coli*  
*Proteus*, indole-negative  
*Proteus*, indole-positive  
*Pseudomonas aeruginosa*  
*Klebsiella*  
*Enterobacter* } species  
*Serratia*

GARAMYCIN Injectable has also been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

## Start with Garamycin

### ■ Broad gram-negative spectrum

Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

## Stay with Garamycin

### ■ Susceptibility of causative organisms confirmed

The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

### ■ Relatively low incidence of adverse reactions

Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

### ■ Bacterial resistance has not been a problem

In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.



in serious gram-negative infections (pneumonia, urinary tract infections, septicemia, and wound infections)\* due to susceptible organisms

On all in-patient services...

**Garamycin<sup>®</sup>**  
**gentamicin**  
**sulfate**  
**Injectable**  
**I.M./I.V.**

**40 mg. per cc.**

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

## WARNING

Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments

or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

**USAGE IN PREGNANCY** Safety for use in pregnancy has not been established.

**On all in-patient services...  
in hospital-acquired gram-negative infections\***

# Garamycin®

## gentamicin sulfate

### Injectable

#### I.M./I.V.

**40 mg. per cc.**

Each cc. contains  
gentamicin sulfate equivalent  
to 40 mg. gentamicin

Also available:  
GARAMYCIN® Pediatric Injectable, 10 mg. per cc.

**GARAMYCIN®** Injectable, brand of gentamicin sulfate U.S.P., injection, 40 mg./cc. Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin  
For Parenteral Administration

#### WARNING

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**USAGE IN PREGNANCY** Safety for use in pregnancy has not been established.

**INDICATIONS** GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

**Pseudomonas aeruginosa**, **Proteus** species (indole-positive and indole-negative), **Escherichia coli** and **Klebsiella-Enterobacter-Serratia** species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is usually indicated as concomitant antimicrobial therapy.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

**CONTRAINDICATIONS** A history of hypersensitivity to gentamicin is a contraindication to its use.

**WARNINGS** See Warning Box.

**PRECAUTIONS** Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

#### ADVERSE REACTIONS

**Nephrotoxicity:** Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

**Neurotoxicity:** Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

**Note:** The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

#### DOSAGE AND ADMINISTRATION

GARAMYCIN Injectable may be given intramuscularly or intravenously.

#### For Intramuscular Administration:

##### PATIENTS WITH NORMAL RENAL FUNCTION\*

**Adults:** The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 cc.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the

usual dose is 60 mg. (1.5 cc.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

\*In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

#### For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration, in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 cc. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution, in both instances should normally not exceed 1 mg./cc. (0.1%). The solution is infused over a period of 1 to 2 hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically pre-mixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

**HOW SUPPLIED** GARAMYCIN Injectable, 40 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per cc., 2 cc. multiple-dose vials for parenteral administration.

APRIL, 1972  
AHFS Category 8:12.28

**For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.**



## Audio Cassette Tapes Now Available from AMA

The American Medical Association has recently inaugurated for its membership an Audio Cassette tape service through which highlights of recent AMA meetings, symposia and conferences are summarized.

These tapes are also available to editors and writers. Each plays one hour. Meeting reports now available on tape are as follows:

26th AMA Clinical Convention

Air Pollution Research Conference

32nd Annual Congress on Occupational Health

Medical Complications of Drug Abuse

Panel Discussion—Present Consumer Reality and Its Determinants

Symposium on Manpower Distribution

American Association of Foundations for Medical Care

14th National Conference on Medical Aspects of Sports

Symposium on Environmental Quality and Food Supply

1973 National Medicolegal Symposium

26th National Conference on Rural Health

7th National Congress on the Socio-Economics of Health Care

The tapes may be purchased at \$5 each. Address orders to Department of Radio-TV-Film, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

## Home Inhalation Therapy Started on Trial Basis

The remainder of 1973 will be a demonstration period in Central Ohio for an "Inhalation Therapy Home Care Service." Designed to provide inhalation therapy (IPPB) for the respiratory disease patient in the home, the program is jointly sponsored by the Central Ohio Lung Association (formerly Tuberculosis Society), 185 South Fifth Street, Columbus 43215, and the Community Health Care Service of the Columbus Health Department, 181 South Washington Blvd., Columbus 43215.

Patients are referred by a licensed practicing physician. Prescribed treatment is established by the physician on a form provided by the Columbus Health Department. Upon receipt of a referral, a licensed practical nurse places an IPPB unit in the patient's home and instructs him in its use and care. Instruction on the use of oxygen is given if prescribed. After the initial visit by the practical nurse, the referring physician is contacted to deter-

mine if additional nursing services such as breathing exercises, diet counseling, postural drainage, etc., are indicated.

The program provides the IPPB unit for a trial period of 60 days at no cost, but this does not include the cost of medication, oxygen, etc. Toward the end of the 60-day period the physician is requested to assess the effect of the program. If home treatment is to be continued, the patient will have to purchase the necessary equipment.

At the end of the demonstration period, the program will be assessed and the Community Health Care Service will determine its future as a potential part of the overall program.

The American Academy of Family Physicians has announced the second printing of its text *Family Practice*, a basic book for students and residents in family practice and a reference work for practicing physicians. The book contained about 1,065 pages with 350 illustrations. Order from W. B. Saunders Co., West Washington Square, Philadelphia, Pa. 19105; price \$33.00.

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**(See Page 421)**



# Services for Ohio's Crippled Children

## Medical Centers in Ohio Approved to Provide Services for Children Requiring Diagnosis and/or Treatment of Cardiac Conditions

Any physician who believes a child under his care is eligible for treatment under the Bureau of Crippled Children Services may inquire through any one of a number of agencies throughout the State. The following information on these agencies and their services was furnished to *The Journal* by Elizabeth R. Aplin, M.D., Bureau medical director, and Eleanora Hipple, administrative specialist.

ANY INDIVIDUAL under the age of 21 who has an organic disease, defect, or condition which may hinder the achievement of normal growth and development may be eligible for assistance from *The Bureau of Crippled Children Services*, 527 South High Street, Columbus 43215; Telephone (614) 469-4114.

Every State Crippled Children's Agency tries to locate crippled children and must follow certain policies set forth by the Maternal and Child Health Service under Title V of the Social Security Act.

The State must assure a reasonably high standard for personnel and facilities.

Health services of crippled children's programs must be under the direction of a physician.

When a State Agency assumes responsibility for payment of the treatment of a child, the physician in charge must work out a well-rounded plan of care which the agency must approve before payment is authorized.

Every State Crippled Children Service must provide diagnostic services without charge to the children who are brought to its Crippled Children's Clinics.

Since care of a handicapped child may be a financial burden greater than the parents can bear, the agency will help parents with financial planning and may assume part or all of the cost of care, depending on the child's condition and the family resources.

Appropriations are the most important factor

in determining requirements. There are income guidelines to determine eligibility. However, there are often circumstances which may make the higher-income family eligible. This is determined by the State agency on the basis of information submitted by the parents. It is necessary for the agency to budget carefully so that the program may help families in greatest need.

Following is a list of Heart Centers that have been designated by the Bureau to provide the types of heart services described. Approval of these Centers follows careful survey and study by the Bureau of Crippled Children's Committee for Review of Standards for Pediatric Cardiology throughout Ohio in compliance with the guidelines established by the American Heart Association.

Referrals of children, under 21, with any type of suspected cardiac condition should be directed to these centers as they are equipped to provide the quality of services for any child throughout Ohio.

If it appears that the parents will require assistance from the Bureau of Crippled Children's Services, the procedure will be greatly simplified if initial referral is made to the listed Cardiac Centers.

The list indicates names of team members and the type of services available.

Children's Hospital  
West Buchtel Avenue & Bowery Street  
Akron 44308  
Tele: 216/253-5531  
(Catheterization, Closed Heart Surgery)  
John D. Kramer, M.D.  
V. V. Sreenivasan, M.D.  
Yenching Wu, M.D.  
Wm. Falor, M.D.  
Frank Lansden, M.D.  
Earl Shields, M.D.

Children's Hospital  
Elland and Bethesda Avenue  
Cincinnati 45229  
Tele: 513/861-8000  
(Catheterization, Closed Heart Surgery, Open  
Heart Surgery)

David Schwartz, M.D.  
Samuel Kaplan, M.D.  
George Benzing, III, M.D.  
Richard Meyer, M.D.  
J. A. Helmsworth, M.D.  
Tracy Schreiber, M.D.

Good Samaritan Hospital  
3217 Clifton Avenue  
Cincinnati 45220  
Tele: 513/872-1400  
(Catheterization)  
Georges Daoud, M.D.

Babies and Children's Hospital  
2103 Adelbert Road  
Cleveland 44106  
Tele: 216/791-7300  
(Catheterization, Open Heart Surgery, Closed  
Heart Surgery)  
Victor Whitman, M.D.  
Jerome Lieberman, M.D.  
Jay L. Ankeney, M.D.  
D. W. van Heeckeren, M.D.

Cleveland Metropolitan General  
3395 Scranton Road  
Cleveland 44109  
Tele: 216/398-6000  
(Catheterization)  
Elmerice Traks, M.D.

Children's Hospital  
561 South 17th Street  
Columbus 43205  
Tele: 614/253-8841  
(Catheterization, Closed Heart Surgery, Open  
Heart Surgery)  
Don M. Hosier, M.D.  
Jo Craenen, M.D.  
Howard Sirak, M.D.  
James W. Kilman, M.D.  
John S. Vasko, M.D.  
Thomas E. Williams, M.D.

Dayton Children's Medical Center  
1735 Chapel Street  
Dayton 45404  
Tele: 513/461-4790  
(Catheterization, Closed Heart Surgery)  
Dwight Tuuri, M.D.  
Stuart M. Denmark, M.D.  
Kenneth H. Oberhue, M.D.  
Richard A. DeWall, M.D.

## Cardiac Clinics Sponsored by Ohio Bureau of Crippled Children Services

Adams County Health Department  
West Union  
Louise Rauh, M.D.

Nelsonville TB Center  
Nelsonville  
Donald Hosier, M.D.

Martins Ferry Hospital  
Martins Ferry  
Donald Hosier, M.D.

Gallia County Health Department  
Gallipolis  
Donald Hosier, M.D.

Greene County Health Department  
Xenia  
Dwight Tuuri, M.D.

Highland County Health Department  
Hillsboro  
Louise Rauh, M.D.

Hocking County Health Department  
Logan  
Donald Hosier, M.D.

Lawrence County Health Department  
Ironton  
Donald Hosier, M.D.

Preble County Health Department  
Eaton  
Dwight Tuuri, M.D.

Washington County Health Department  
Marietta  
Donald Hosier, M.D.

Referrals to these clinics are accepted from local physicians who have determined that the child under age 21 requires evaluation by the pediatric cardiologist. Physicians may direct their referrals to the local health department. Included are names of pediatric cardiologists at respective clinics.

# Continuing Education Opportunities for Physicians in Ohio

## June

**Laparoscopies**—Youngstown Hospital Association; June 7, 8:00 p.m. Guest Professor, E. P. Peterson, M.D., Women's Hospital of the University of Michigan Medical Center.

**Infectious Hepatitis** (G. I. Conference) — St. Elizabeth Hospital, Youngstown, June 12, Dr. Gaylord.

**Cleveland Symposium on Infectious Diseases** — Cosponsored by the Cleveland Clinic Educational Foundation and the American Society for Clinical Pharmacology and Therapeutics, at the Clinic, 9500 Euclid Ave., Cleveland 44106, June 13-14.

**Visiting Professor Program** — Akron City Hospital, 525 Market St., June 14-15; Beverley T. Mead, M.D., chairman, Department of Psychiatry, Creighton University School of Medicine.

**Obesity** (Endocrinology Conference) — St. Elizabeth Hospital, Youngstown, June 16, Dr. Jung.

**Myelofibrosis with Myeloid Metaplasia** (Hematology Conference) — St. Elizabeth Hospital, Department of Medicine, Youngstown, June 18.

**Malabsorption Syndrome** (G. I. Conference) — St. Elizabeth Hospital, Youngstown, June 19, Dr. Gregori.

**Endocrine Problems** (Endocrinology Conference) — St. Elizabeth Hospital, Youngstown, June 23; Dr. Jung.

**Cirrhosis of the Liver** (G. I. Conference) — St. Elizabeth Hospital, Youngstown, June 26, Dr. Gaylord.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

**Hypothyroidism** (Endocrinology Conference) — St. Elizabeth Hospital, Youngstown, June 30, Dr. Jung.

## July

**Urologic Outing** — Sponsored by the OSU College of Medicine, July 30-August 1, at Atwood Lodge (between New Philadelphia and Carrollton); for details contact the Center for Continuing Medical Education, A-352 Starling Loving, 320 W. Tenth Ave., Columbus 43210.

## August

**Ohio Academy of Family Physicians Annual Scientific Assembly** — Sheraton-Columbus Motor Hotel, downtown Columbus, August 3-5. For details, contact the Academy at 4075 N. High St., Columbus 43214.

**Fifth Semiannual Short Course on Laser Safety**—Sponsored by the Medical Laser Laboratory and the office of Continuing Medical Education (CONMED) of the University of Cincinnati; August 6-10; at the University; tuition \$325; course director, R. James Rockwell, Jr., for details contact CONMED, 114 Medical College, Cincinnati 45219; phone 513/861-8000, Ext. 405.



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and psychology for rheumatoid arthritis



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Each tablet contains aspirin, 600 mg. (10 grains); magnesium hydroxide, N.F., 150 mg.; aluminum hydroxide dried gel, 150 mg.

**Unique design.** In shape, size and color, CAMA looks like no other aspirin. It gives patients an "individualized" medication—one they may find more acceptable and possibly respond to more positively.

**Fits prescribing patterns.** CAMA's 10-grain aspirin strength is suited to the higher dosage regimens generally used for arthritis.

**Adjustable dosage.** Scored tablet lets you increase or decrease dosage in 5 or 10 grain increments.

**Economical.** CAMA costs no more per dose than many 5-grain buffered aspirin tablets. Give your arthritic patients the added benefits of CAMA. Ask your Dorsey representative for a generous supply or write Director of Professional Relations.

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Lincoln, Nebraska 68501

# Community Health News

## Ohio Department of Health

JOHN H. ACKERMAN, M.D., Deputy Director

Continuing rainfall this spring has resulted in a great deal of standing water. We anticipate large mosquito populations this summer and an increased incidence of California Encephalitis. The Ohio Department of Health provides diagnostic serologic testing for suspected cases. Acute and convalescent sera are required.

\* \* \*

Small outbreaks of erythema infectiosum (Fifth Disease) have been occurring around the State. Isolation and exclusion from school are not required for this disease except when symptoms are severe enough to require bed rest. Some adults may show symptoms of arthralgia if infected.

\* \* \*

Several small outbreaks of rubella have occurred in high schools this past winter. There has

been no spread to the community or to preschool children. Some diagnostic problems have arisen because of the concurrent incidence of erythema infectiosum. Diagnostic serology for rubella infections is available from the Ohio Department of Health.

\* \* \*

During the first nine months of the gonorrhea control program, 198,000 females have been cultured. Of these, 9,000 were positive or approximately 5 percent. The ratio of male to female cases has been reduced from 1:7:1 to 1:4:1. There has been overall only a slight increase in total cases in 1972. Continuing efforts to detect infections in females may result in decreases in incidence of gonorrhea this year.

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## Wanted: Notes on Renowned Physicians and Their Faith

The following communication was sent to *The Journal* with the request that it be published for the information of Ohio physicians and other interested persons.

"I am editing a book on renown and notable physicians and their faith.

"I am interested in obtaining contributors who have a special knowledge of the faith and/or religion of one or more notable and outstanding physicians. I am considering such physicians as Sir William Osler, and Sir William Fleming, however the notable physicians could still be alive.

"Anyone interested in this project or who would suggest renown physicians to write about may contact me at the following address: Claude A. Frazier, M.D., 4-C Doctor's Park, Asheville, NC 28801."

## American College of Surgeons To Meet in Chicago

The 59th annual Clinical Congress of the American College of Surgeons will be held in Chicago, October 15-19. Official headquarters will be the Conrad Hilton Hotel, with sessions at McCormick Place and several area hotels.

The Clinical Congress is open to all doctors of medicine. Official forms for registration, housing and postgraduate courses are available. Contact Fred Spillman, Convention Manager, American College of Surgeons, 55 E. Erie Street, Chicago, Illinois 60611; phone 312/664-4050. Dr. Edwin W. Gerrish, assistant director, is in charge of all scientific programs for the College.

Dr. Kev D. McMurray, Jr., Medical Director, the Procter and Gamble Company, Cincinnati, was named to the Board of Directors of the Industrial Medical Association, at the recent 58th annual meeting in Denver.

AVAILABLE FOR THE TREATMENT OF

# impotence

due to androgenic deficiency in the American male.

## Android<sup>®</sup> 5

MUQUETS  
BUCCAL Tabs

Methyltestosterone N.F. - 5 mg.

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Methyltestosterone N.F. - 10 mg.

## Android<sup>®</sup> 25

Methyltestosterone N.F. - 25 mg.

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4-en-3-one.

**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration of excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgen. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

| INDICATION   | Average Daily Dosage Tablets |
|--|------------------------------|
| In the male:   |                              |
| Eunuchoidism and eunuchism   | 10 to 40 mg                  |
| Male climacteric symptoms and impotence due to androgen deficiency | 10 to 40 mg                  |
| Postpubertal cryptorchidism  | 30 mg                        |

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

## Tandearil® helps take the heat off oxyphenbutazone NF Geigy

Tablets of 100 mg.

**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasias); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonyleurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granuloma, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

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# Opinion & Dialogue

## "Prescription drugs – who should determine the maker?"

### Dispenser of Medicine

Clifton J. Latiolais  
President  
American  
Pharmaceutical  
Association



### Maker of Medicine

C. Joseph Stetler  
President  
Pharmaceutical  
Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

#### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MDs have given the impression they are not particularly concerned with the increase in cost of health care to the patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

#### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist, made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

#### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree, puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 25



ould be an obligation of medical  
a ice...

"Medical societies ought to con-  
continuing campaigns to point  
the substantial savings that could  
realized thru deductible insurance  
protection for catastrophic ill-  
s. At the very least, they should, in  
patients' interest, question the  
cts of any insurance organization  
raises health care costs by forc-  
policyholders to buy insurance  
may not need or want and prob-  
won't ever use.

"Too many doctors are indiffer-  
to the economic consequences of  
decisions. Too many, for ex-  
ple, habitually hospitalize patients  
the convenience of the MD. It's  
sense to deny such habits exist...  
"Doctors, thru their medical so-  
ties, have unhesitatingly appealed  
their patients for support in the  
against government interference  
the private practice of medicine.  
the public in the past has re-  
ded. It's time the American Med-  
association and state and local  
cal societies paid off the debt by  
cive action to hold down the cost  
medical care."

## Cost of Drugs

Insurance rates and hospital  
ages are only two factors in health

care costs. The cost of drugs—both  
prescription and nonprescription—is  
another.

And when it comes to drug  
costs, the nation's pharmacists *are*  
*concerned*. Through their national  
professional society, the American  
Pharmaceutical Association, pharma-  
cists are advising the public to use  
nonprescription medication cau-  
tiously and conservatively, and to seek  
the advice of their pharmacist before  
selecting or purchasing such drugs.

## Outdated Laws

The pharmacist also is aware  
that when it comes to prescription  
drugs, often he has an even greater  
opportunity to reduce the cost to the  
patient—with no sacrifice in the qual-  
ity of the medication dispensed. But  
in many states, outdated and anti-  
quated laws prevent the pharmacist  
from engaging in drug product selec-  
tion. "Drug product selection" simply  
means that the pharmacist functions  
in the patient's interest by con-  
sciously choosing, from the multiple  
brands available, a low-cost quality  
brand of the specific drug to be dis-  
pensed in response to the physician's  
prescription order.

Much *misinformation* has been  
purposely spread by those who stand  
to gain financially by maintaining

high drug costs to the public. An end-  
less stream of propaganda has ema-  
nated from the drug industry in an  
effort to persuade the medical profes-  
sion that these so-called anti-substitu-  
tion laws should be retained. And as  
long as these laws are retained, the  
drug industry will continue its current  
marketing practices which contribute  
unnecessarily to high drug costs to  
patients. These practices also are in-  
viting government agencies to expand  
their restrictive controls on physi-  
cians and pharmacists.

## APhA Efforts

As pharmacists, we are con-  
cerned about health care costs. We  
hope that every physician shares our  
concern on this vital issue, and will  
give his personal support to the con-  
structive efforts APhA has undertaken  
in the interest of all patients.

*(For a complete discussion of  
drug product selection, you are invited  
to request a free copy of the "White  
Paper on the Pharmacist's Role in  
Product Selection" from: American  
Pharmaceutical Association,  
2215 Constitution Avenue, N.W.,  
Washington, D.C. 20037.)*

3 drugs that he selects to treat the  
variety of conditions encountered in  
practice. Moreover, the physi-  
cian's choice of a specific brand is  
based on his knowledge of the pa-  
tient's medical history and current  
condition, and his experiences with  
the particular manufacturer's  
product.

Some substitution proponents  
have argued that the dispensing of a  
prescription is a simple two-party  
transaction between the pharmacist  
and the patient, and that a substitut-  
ing pharmacist may avoid even a  
critical breach of contract by simply  
informing the patient that he is making  
a substitution. I would judge that  
courts would be sympathetic  
to a pharmacist who substituted  
without physician approval and who  
did not take a legal defense that seeks  
to make the patient responsible for  
the pharmacist's actions.

## Reduced Prescription Prices?

Substitution advocates are  
arguing to the consumer, and par-  
ticularly the consumer activist, that  
reduced prescription prices could  
be achieved by legalization of substitution.  
I have seen absolutely no evidence  
to justify this claim. To the contrary,  
experience in Alberta, Canada, where  
substitution is authorized, suggests

the opposite.

Many pharmacists understand-  
ably are concerned about the cost of  
maintaining multiple stocks of similar  
products. While there is no doubt that  
inventory costs rise when additional  
brands are stocked, it would be inter-  
esting to know how much they rise,  
and how many pharmacists actually  
stock *all* brands—of, say, ampicillin  
or tetracycline—or how long they  
keep "slow moving" products on their  
shelves before they are returned for  
credit. To ask that the industry elimi-  
nate multiple sources is to ask com-  
petitors to stop competing.

## Drug Substitution—A License for the Unethical

Anti-substitution repeal would  
favor "corner cutting" pharmacists  
and manufacturers. For them, free  
substitution would be not a right, but  
a license. As an aftermath, it is quite  
likely that the confidence of both phy-  
sicians and patients in the profession  
of Pharmacy would be eroded, as  
revelations about the unconscionable  
behavior of an undisciplined few were  
magnified in the press or in profes-  
sional circles.

## Summary

In short, what the American  
Pharmaceutical Association advo-

cates as a broad-spectrum panacea  
looks to us to be not only a minority  
view (advocacy of substitution is by  
no means a uniform policy in Phar-  
macy), but also an extraordinarily  
costly and ineffective remedy, whose  
side effects are odious. We believe  
(1) that an impressive majority of  
pharmacists prefer to work with  
Medicine and with industry, for the  
consumer, and for the general good,  
(2) that they seek the privilege to sub-  
stitute when the patient might gain  
and when the patient's doctor agrees,  
and (3) that they seek to work for the  
resolution of genuine grievances  
openly and professionally.

*(For amplification of PMA views,  
please write for our booklet, "The  
Medications Physicians Prescribe:  
Who Shall Determine the Source?"  
It is available from: Pharmaceutical  
Manufacturers Association, 1155  
Fifteenth Street, N.W., Washington,  
D.C. 20005.)*

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005





## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 306433

## Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

Insomnia often accompanies a cardiovascular episode. How many nights does he lie awake, awaiting exactly what he fears most . . . another stroke, another heart attack? He doesn't need fear. He needs sleep.

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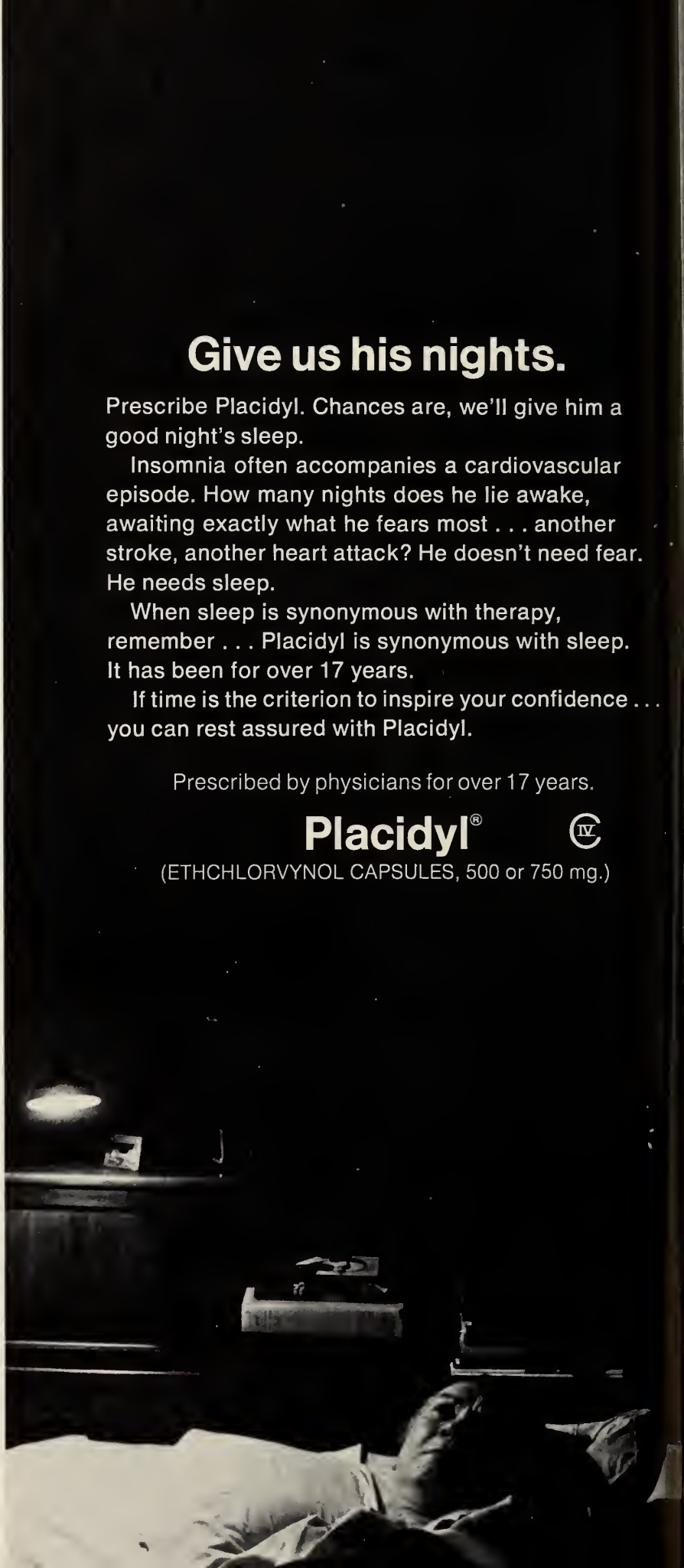
If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

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Ⓢ

(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)





# American Medical Association to Convene in New York

**P**HYSICIANS will have an opportunity to experience "a new approach to an interchange of knowledge" at the 122nd Annual Convention of the American Medical Association scheduled for June 24-28 in New York City. Entitled "Confluence '73," the convention promises to present one of the most comprehensive and updated programs of all times.

The April 16 issue of the *Journal of the American Medical Association* features the United Nations on its cover as a reminder of the New York setting. This issue contains full details on the convention, including hundreds of program features in store for selection by physicians.

Beginning on page 352 of that issue is a listing of postgraduate courses, notes on credits toward the AMA Physician's Recognition Award program; also notes on registration fees where these apply.

Physicians who are intrigued by the controversy about acupuncture will find a general session devoted to the subject under the title "Acupuncture and Western Medicine," scheduled for Wednesday afternoon, June 27.

Details on Section programs begin on page 357. Virtually every field of medicine and surgery is represented in these sections which comprise some 20 pages of program material.

The AMA Convention is known for its updated motion pictures on medical and surgical subjects. See the listing of these film symposiums on page 377 of the April 16 *JAMA*. In many cases the film authors will appear in person for further

discussion.

World famous is the AMA Scientific Exhibit and this display will be located in the New York Coliseum. Exhibits will be arranged by specialty so that the physician may easily select the exhibits in which he is particularly interested. Special exhibits will include the Arthritis Clinic in which patients will be on hand for live teaching sessions, plus the exhibits on fractures, fresh tissue pathology, pulmonary function, resuscitation, and arthritis and rheumatism.

The Woman's Auxiliary to the AMA will meet at the Waldorf-Astoria Hotel with sessions beginning on Sunday, June 24. As in previous years, the Auxiliary will sponsor programs for pre-teens and youth who accompany their parents to New York.

Once again the American Physicians' Art Association will sponsor an exhibit of physicians' art at the New York Coliseum. Included will be displays of paintings, sculpture, photography, and crafts by members of the profession. President of the art organization is Helmut Nathan, M.D., 667 Madison Ave., New York 10021.

Every physician owes it to himself to attend at least one session of the AMA House of Delegates and witness the policy-making body of the Association in action. The House convenes at 2:00 p.m. on Sunday, June 24 in the Imperial Ballroom of the Americana Hotel. On Monday reference committees will begin hearings on the various resolutions and other matters presented to the House and will report back at the final session.



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## Silastic Cranioplasty

JAMES A. LEHMAN, JR., M.D.

IT HAS BEEN STATED that "any part of the human body that is 'lost' must be replaced in kind. If you cannot be exact, do the next best thing."<sup>1</sup> Large and complex craniofacial defects, especially those in the forehead, periorbital, and glabellar area, often do not lend themselves to accurate correction with autogenous tissues. The next best thing appears to be the reconstruction of the defect with implant material.

It is not the scope of this paper to discuss the numerous methods to reconstruct craniofacial defects using either autogenous tissue<sup>2,4</sup> or various implant materials.<sup>5,6</sup> A procedure is presented which has produced a satisfactory cosmetic and functional repair in seven patients with large craniofacial defects.

### Technic

A facial moulage is made of the patient from which a study model is made. Using this model (and appropriate x-ray films) for reference, a block of silastic is roughly carved to the size of the

### The Author

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defect. Final shaping is done in the operating room because the model represents the external defect and not the actual bony defect. In the operating room, the defect is exposed by an incision placed away from the implant area. The periosteum is stripped from the edges of the defect and the final shaping of the prosthesis is performed. The prosthesis is sutured to the edges of the bony defect using nylon sutures. Wire was found to be unsatisfactory as it cuts through the silastic. In the first 10 to 14 days after surgery, seroma formation is common but is not a serious problem.

### Case Reports

*Case 1.* This 23-year-old man was injured by a grenade in February 1968. There was loss of a portion of the left frontal bone, including the supraorbital ridge, measuring 3 to 7 centimeters

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Submitted August 23, 1972.

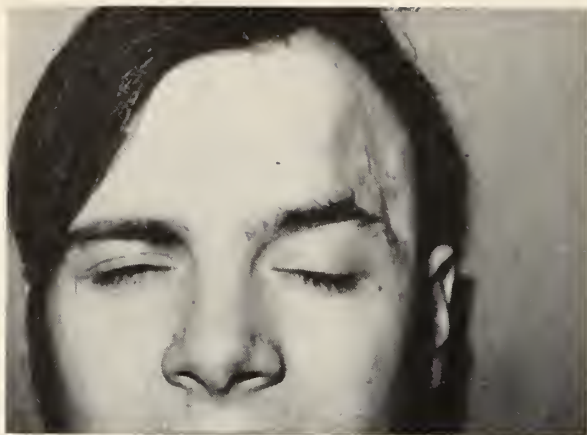


FIG. 1A. Before cranioplasty (case 1).



FIG. 1B. After cranioplasty with silastic implant (case 1).

(Fig. 1A). In April 1970, the defect was corrected with a silastic implant (Fig. 1B).

*Case 2.* This 22-year-old man sustained a fragment wound of the right frontal area in June 1969, producing a defect measuring 7 X 9 cm (Fig. 2A). In May 1970, a silastic implant was inserted (Fig. 2B).

*Case 3.* This is a 21-year-old man, who sustained fragment wounds of the right temporal



FIG. 2A. Before cranioplasty (case 2).



FIG. 2B. After silastic cranioplasty (case 2).





FIG. 3A. Defect prior to surgery (case 3).

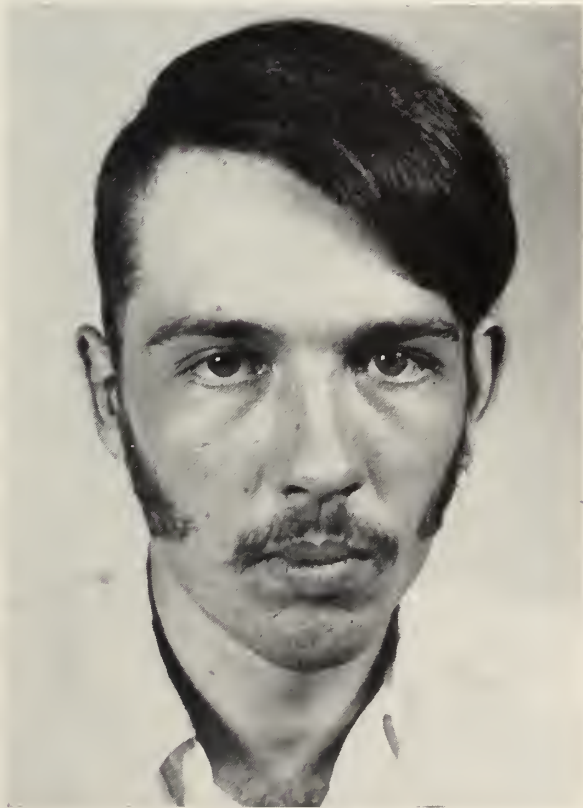


FIG. 3B. After silastic implant (case 3).

area in September 1968. After initial treatment, the patient had a 7 X 9 cm defect (Fig. 3A). In April 1970, the defect was corrected with a silastic implant (Fig. 3B).

*Case 4.* This 21-year-old man sustained a gunshot wound of the right frontal parietal area in September 1969. A skull defect measuring 8 X 9 cm was present when he was first seen (Fig. 4A). The



FIG. 4A. Before cranioplasty (case 4).



FIG. 4B. After silastic cranioplasty (case 4).

defect was corrected with a silastic implant in May 1970.

### Discussion

Four case histories with photographs have been presented to illustrate the correction obtained with silastic cranioplasty. Seven patients have been treated to date, and they have been followed for a minimum of 20 months. No complications have developed. Seroma formation in the early postoperative period resolved without treatment.

Large craniofacial defects produce both the danger of physical injury to the brain and of a visible cosmetic deformity. While the possibility of injury should not be minimized, the psychologic effects of the deformity are frequently severe. The change in these patients' personalities after correction of their defects was both remarkable and rewarding.

This method requires only some easily obtainable skill in carving the silastic block. The purchase of expensive equipment to prefabricate a silastic prosthesis as advocated by some authors is unnecessary.<sup>7</sup>

### Summary

A method of correcting craniofacial defects using carved silastic block has been presented. This has proved to be a simple, safe, effective and inexpensive technic which has given good cosmetic results.

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## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

After a bout of right otitis media, which was treated with a five-day course of ampicillin, a 10-year-old boy continues to have drainage from the

ear, pain, and a low-grade fever.

Examination reveals marked swelling of the posterosuperior portion of the right external auditory canal, pus in the canal, and slight tenderness over the mastoid process.

What is the most likely diagnosis, how can it be confirmed, and what is the treatment?

(See p. 463 of this issue for further information and discussion.)

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Submitted February 22, 1973.

# Learning Disabilities and the Physician

PAUL G. DYMENT, M.D., AND CLARE A. ROBINSON, M.S.

IN OHIO THERE ARE about 5,000 children who have normal potential ability for education but are so disabled educationally that they must participate in special school programs. In earlier, less demanding times, most of these children merely would have dropped out of school at an early age, but statutory regulations of child labor and compulsory education have largely eliminated this simple solution to the problem.

Parents and educators are now turning to physicians for help in evaluating the increasing number of children who are academic underachievers, or who have behavior problems, or both. Often the problem child is accompanied to the physician's office by distraught parents who cannot cope with the stresses the child's behavior imposes on the entire family. Frequently the child himself is at a point where accurate diagnosis and help could mean the difference between his leading a productive life or one marred by serious maladjustments.

What can a physician do, especially in communities where the guidance and assistance of educational specialists are not readily available? There is much that primary care practitioners can accomplish, particularly in providing help for those children whose problems are not yet severe.

## Minimal Brain Dysfunction

There are many causes of *learning disabilities*. These include the obvious: impaired vision and hearing, cultural deprivation, emotional disorders, intellectual retardation, inadequate motivation, and poor academic teaching. In this discussion we are primarily concerned with the *minimal brain dysfunction syndrome* (MBD). Clemens and Glaser have defined this disorder: "The diagnostic and descriptive categories included in the term minimal brain dysfunction refer to children of near average or higher general intelligence with

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learning or certain behavioral abnormalities ranging from mild to severe which are associated with suspected dysfunction of the central nervous system. These may be characterized by combinations of deficits in perception, conceptualization, memory, language, control of attention, impulsivity, or awkwardness. These aberrations may arise from genetic variation, biochemical irregularities, perinatal brain insults, illnesses or injuries sustained during the years critical to the development of the central nervous system, or unknown causes."<sup>1</sup>

This is a broad definition, and any child with MBD may have one or more of the stigmata listed. He may be hyperactive, or he may have a specific reading disability with evidence of a visual-motor perceptual defect, or he may have all of these signs.

More than 40 English terms have been used to describe these children.<sup>2</sup> "Minimal brain injury" was discarded when it became evident that most of these children had no evidence by history of a central nervous system insult. The term "minimal cerebral dysfunction" has been criticized because it presumes that the lesion, whether biochemical or anatomic, is located in the cerebrum, a presumption for which there is little evidence.

A child with a basic emotional disturbance may be brought to the physician with the same behavioral picture of school underachievement and hyperactivity. It is difficult to distinguish the chil-

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Submitted November 24, 1972.



dren in this group from children with MBD, because emotional stress is placed upon children with MBD as a direct result of their school underachievement. Until recently, school personnel frequently expected the medical profession to identify and separate the two groups so special classes could be organized solely for children with MBD. However, it is now recognized that the therapeutic benefits of small homogeneous classes with shorter class periods are basically the same, whether the children have neurologic dysfunctions or emotional disturbances. Although Ohio's educators are accepting the philosophy that we should refer to these children as having a "learning and/or behavior disability," state legislators have been mainly willing to provide financial support for classes for the "neurologically handicapped." Other states may use different terminologies such as "educationally handicapped," the term used in California.

Although there is no "typical" child with MBD, a rather common history would be: A 7-year-old boy is referred to a physician because of hyperactivity since infancy, easy distractibility, and school underachievement. Because of the distractibility, he cannot screen out the countless inconsequential auditory and visual stimuli to which everyone is exposed. His attention rapidly shifts from one thought to another, and this short attention span interferes with the learning process. He may also have emotional lability, impulsivity, or low frustration tolerance.

A physical examination usually reveals nothing, although some children demonstrate equivocal neurologic signs. These so-called "soft signs" include nonspecific awkwardness, dysdiadochokinesia, confusion in directionality, articulation disorders, fine tremor of the fingers when they are separated while the arm is extended, inability to stand, skip, or hop on one foot, and scrawling, semilegible handwriting. Any one of these neurologic signs alone would not be significant, but the child with MBD frequently has several, and their presence is believed by many to support this diagnosis. This is by no means a universal belief, however, and many attach no significance to these soft signs. Although the soft signs are also found in normal children, they do not appear as often. The results of one controlled study<sup>3</sup> indicated that such equivocal signs of central nervous system dysfunction are true signs of organicity.

### Testing

Since the behavioral pattern of children with MBD and those with some types of emotional disturbance are similar, the differentiation between these two is frequently difficult, if not impossible. A disturbed psychologic picture of the home does not necessarily indicate that this is the etiology of the learning disability. Children from disturbed homes are just as likely to have neurologic dys-

function as children from more stable homes. The physician should attempt to obtain significant psychologic evidence from the patient's history, although psychologic deficits ideally should be assessed by a psychologist. An estimate of basic intelligence should be made to determine the child's learning capacity. The Wechsler Intelligence Scale for Children (WISC) is an example of the tests commonly used by psychologists to assess intelligence. The Bender-Gestalt Test measures visuomotor perceptual ability and also gives an impression of the child's capacity to perform a task. Should the services of a psychologist be unavailable, the physician can easily administer one of the quick tests designed for this purpose such as the Peabody Picture Vocabulary Test.\* Such a test can estimate the child's basic intelligence through this measure of vocabulary comprehension. If the inferred capacity of the child is significantly higher than his achievement, the depression of function may be due to a learning disability.

Whether an electroencephalogram (EEG) is indicated in the evaluation of these children has been reviewed recently by one of the authors,<sup>4</sup> and it appears that the worth of this tool has been greatly overestimated. Although it is true that abnormal EEGs are reported in about 50 percent of children with MBD, in control series, abnormal EEG findings have been reported in from 10 to 30 percent of normal children. This makes the interpretation of any particular abnormal EEG result hazardous at best. If abnormal, it should be considered as just one more fact *suggesting* neurologic dysfunction. If it is normal, it neither negates nor confirms the diagnosis of MBD.

Although it is true that Ohio regulations require an EEG prior to entry of a child into a neurologically handicapped class, this is not being enforced in our experience, and the regulations do not specify that the EEG finding must be abnormal. It is not the practice of this clinic to order EEGs routinely, and the Ohio Chapter of the American Academy of Pediatrics now (September 1972) has a committee urging the discontinuance of this regulation of the Ohio Department of Special Education.

### Management

After MBD has been diagnosed, the physician should discuss it with the family, emphasizing that the child is not mentally retarded and that the parents are not necessarily at fault for the behavioral problem. The physician can point out that a hyperactive child is often helped by changing his home environment to establish more consistent life patterns. For example, dinner, bath, and bedtime should be at the same time every

\*Available from American Guidance Service, Inc., 720 Washington Ave., S.E., Minneapolis, Minn. 55414

night so that the child does not begin to get "worked up" in protest, knowing that the deadline is inevitable; if a weekend trip is planned, he should not be told about it until the last moment to prevent his becoming more and more excited and unmanageable as the weekend approaches.

Millichap has recently reviewed all of the studies involving medication for children with MBD with hyperactivity.<sup>5</sup> Treatment with methylphenidate helped 80 percent, and 69 percent improved when dextroamphetamine was given; hyperkinetic behavior was controlled in 60 percent of children treated with chlorpromazine, or chlordiazepoxide. It would be most rational, therefore, to commence a therapeutic trial with the most effective drug, which fortunately also happens to be the one with the fewest side effects. Our usual regimen is to start with a 5-mg or 10-mg tablet of methylphenidate each morning, depending upon the child's age. This is increased by one-half tablet every week until one of the following occurs: a definite good effect, toxicity in the form of even more hyperactivity and irritability, or a maximum of 60 mg is reached. When the effectiveness of the medication is established, parents frequently report that the effect wears off by early afternoon. In such cases, a dose at noon, usually one-half the morning dose, might be required.

Should methylphenidate be unsuccessful, the other drugs would be tried in the order listed, although dextroamphetamine would not be used if the child became more hyperactive with the methylphenidate. It may be necessary to continue giving the drugs for several years until symptoms and signs of MBD naturally lessen with age. By age 11 years, most children will not require further medication, even though some residual evidence of the condition may persist through adulthood. The drug may be withheld during the summer vacations and weekends when the school pressures are absent. At least once a year the child should have a trial without medication to determine whether treatment is still necessary.

What does drug therapy accomplish for these children? By increasing the attention span and decreasing the hyperactivity, these drugs enable the child to learn more in the regular classroom situation and thus to be relieved of some of the psychologic trauma of significant underachievement. School failure itself can produce frustration and anxiety; this in turn decreases the attention span even more, and school problems worsen.

Of course, improved classroom performance does not depend solely on medication or on the skill of the physician, since there are many facets of the problem of the MBD child over which the physician has no direct control. Foremost among these is the educational milieu in which the child finds himself.

Because parents will find a considerable gap

between what is needed and what is actually available in public school systems, they should be encouraged to join the local Association for Children with Learning Disabilities. This organization of parents and interested professionals is working to awaken public interest and gain more public assistance both for educational facilities and special training of teachers. Parents should be directed to their nearest local group or they may help organize one with the assistance of the state office. The Ohio Chapter of the Association for Children with Learning Disabilities is located at 3490 Far Hills Avenue, Kettering, Ohio.

Physicians should influence local and state educational authorities to encourage adequate funding for these special educational classes as well as for programs to train special education teachers.

For the majority of children with MBD, referrals to diagnostic centers or pediatric neurologists are not necessary. In most cases, what is needed is a physician who will not shrink from the task of helping these children merely because he does not have specialists near at hand. A sensitive and knowledgeable practitioner can render very effective help by combining the principles outlined in this article with his understanding of the family dynamics.

### Summary

A large number of children in Ohio are being brought to their physicians because of school problems or behavior problems related to school failure. A significant number of them have the minimal brain dysfunction syndrome, and this article discusses the diagnosis and management of this condition. It is stressed that therapy is most successful when educational and environmental methods are utilized, and that drug therapy frequently can be helpful as an adjunct to the other forms of treatment.

### Generic and Trade Names of Drugs

Methylphenidate — Ritalin (CIBA)  
Dextroamphetamine—Dexedrine (Smith Kline & French)  
Chlorpromazine — Thorazine (Smith Kline & French)  
Chlordiazepoxide hydrochloride — Librium (Roche)

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# March Hemoglobinuria

## Report of a Case After Basketball and Congo Drum Playing

KENNETH A. SCHWARTZ, M.D., AND HERBERT C. FLESSA, M.D.

FLEISCHER,<sup>1</sup> IN 1881, is credited with the first case report of hemoglobinuria associated with marching. What causes hemoglobin to appear in the urine after marching? Current theory suggests that trauma to red blood cells in the soles of the feet may be responsible. Recent case reports of traumatic hemoglobinuria caused by karate exercises<sup>2</sup> and after congo drum playing,<sup>3</sup> suggest that trauma to the hands may also initiate this syndrome. We report the following case, where trauma to both hands and feet produced the syndrome of march hemoglobinuria.

### Case Report

The patient is a 20-year-old Negro man. He first noticed dark urine, vague headache, and lower abdominal pain at age 17 years after a vigorous basketball game on a cement surface. In June 1970, he experienced a similar episode after an evening's performance with the congo drum, an instrument played by striking the taut surface directly with the hands. The patient, emphasizing the vigor with which the drum is played, said that he usually became exhausted after an evening's performance. The dark urine and generalized discomfort disappeared in 12 hours. He has had

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several episodes since. Each has occurred after playing the congo drum. Between episodes he is free of symptoms.

Physical examination on numerous occasions was negative except for a traumatic defect in the right lens sustained as a child. No lumbar lordosis was present.

The following laboratory data were obtained from several emergency room visits during acute episodes and from one hospitalization at a neighboring community hospital while he was in normal health. Plasma analysis during an acute attack showed 292 mg per 100 ml hemoglobin, no myoglobin, lactic dehydrogenase (LDH) 475 mU/ml and bilirubin 1.5 mg per 100 ml. The urine during acute attacks was almost black. Chemical analysis showed hemoglobin to be present. Microscopic examination revealed no red cells. Plasma and urine analyses between acute episodes were negative for hemoglobin. Immuno-electrophoresis, both during symptomatic and asymptomatic periods, revealed haptoglobin to be decreased strikingly. Quantitative haptoglobin measured during an asymptomatic period was 75 mg per 100 ml. (Normal haptoglobin in our laboratory is 100 to 150 mg per

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Submitted October 31, 1972.



100 ml.) At no time was the patient found to be anemic. Peripheral blood smear, white blood cell and differential counts, reticulocyte count, erythrocyte sedimentary rate, sodium, potassium, carbon dioxide, glucose, blood urea nitrogen, calcium phosphate, total protein, albumin, alkaline phosphatase, serum glutamic oxaloacetic transaminase levels and urine culture were all normal. His hemoglobin was type A, and a sickle cell preparation was negative.

### Comment

Our patient is interesting from several points of view. His hemoglobinuria is provoked both by basketball and by congo drum playing. Repeated trauma either to hands or feet produced hemoglobinuria. Recent reports emphasize a traumatic etiology of march hemoglobinuria.<sup>4,6</sup> Usually this syndrome occurs in young males after walking or running on hard surfaces.<sup>7</sup> Patients commonly present with dark urine and vague abdominal pain. In long-distance runners, these attacks can be relieved by decreasing the trauma between the feet and the running surface.<sup>4,6</sup> If these athletes run on grass or if foam rubber cushions are inserted in shoes, attacks are prevented. Indeed, these clinical correlations were further substantiated by Davidson's experiment.<sup>4</sup> Capillary tubes filled with blood were inserted into the soles of long-distance runners' shoes. The blood in the tubes obtained after running on a hard surface showed more hemolysis than the blood obtained after running on grass.<sup>4</sup> Also, in the patient whose hemoglobinuria was preceded by karate exercise, foam paddings applied to the hands prevented recurrent attacks.<sup>2</sup>

Another factor implicated in hemoglobinuria is decreased hemoglobin-carrying protein, haptoglobin.<sup>8</sup> Gilligan in his studies of a cross-country team suggests that "hemoglobinemia sometimes accompanied by hemoglobinuria occurs in man with sufficient frequency after strenuous runs to be considered physiological under these conditions."<sup>9</sup> Hemoglobin is not found in the urine unless the plasma hemoglobin level exceeds the binding capacity of haptoglobin.<sup>10-12</sup> Hence, in a patient with reduced resting hemoglobin binding power, traumatic exercise with physiologic release of hemo-

globin, might overload an already reduced hemoglobin binding capacity and result in hemoglobinuria. Others have noticed reduced haptoglobins in march hemoglobinuria and have commented on a possible relationship to the hemoglobinuria.<sup>4,8,11</sup>

### Summary

We have reported a patient in whom trauma to both hands and feet produced hemoglobinuria. We believe this supports the theory that trauma induces this syndrome and we agree with others that the name should be changed to traumatic or exertional hemoglobinuria.

**Acknowledgment:** We are grateful to Dr. Helen Glazer and Mrs. Bertha Furnier for performing the special hematologic studies.

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# Traumatic Tricuspid Regurgitation

## Case Report of a Subtle Clinical Diagnosis

ARVINDKUMAR R. SHAH, M.D., AND JOSEF EDELSTEIN, M.D.

CARDIAC INJURY, secondary to nonpenetrating trauma, has become increasingly important in this age of high-speed transportation, industrial mechanization, and community social violence. Traumatic tricuspid regurgitation is a rare but well-tolerated condition.<sup>1</sup> We have found 20 cases previously described,<sup>1-15</sup> but we believe it is probably more common than thus far suspected. The proper diagnosis is usually delayed, owing to lack of symptoms and its benign course. The purpose of this report is to document one further case with a long-term follow-up of nine years. The clinical features of this patient will be discussed and compared with the previously reported cases.

### Case Report

In 1963, at the age of 50 years, this patient considered to be in good health, had, as a consequence of gun-shot wounds to his neck, a serious automobile accident with a severe, nonpenetrating, steering wheel trauma to his chest. Clinical evidence of cardiac injury was lacking immediately after the accident, although during his hospitalization, several observers were impressed by the finding of unexplained prominent neck pulsations assumed to be arterial in origin. However, central cardiac findings were considered normal, and the diagnosis of tricuspid insufficiency was not made at that time. It is important to note that the same physicians had examined the patient before the accident and the neck pulsations had been reported as normal. His previous history included an episode of bronchitis and pneumonia and symptoms of renal calculi. In October 1971, at the age of 59 years, he complained of general weakness and impotence.

Physical examination revealed an acyanotic, 59-year-old, white man with no respiratory distress. His heart rate was regular at a rate of 80 beats per minute. His blood pressure was 130/80 mm Hg. There were visible and palpable prominent systolic pulsations of the jugular veins. The liver was palpable 5 cm below the right costal margin and was also pulsatile in systole. A normal left ventricular apical impulse was present in the fifth left intercostal space and the midclavicular line. In the left parasternal area, a right ventricular systolic

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impulse was well felt. There was a soft, late systolic murmur best heard at the left sternal edge, which increased on inspiration. The second sound split normally and had a normal pulmonic component. No peripheral edema was present. The rest of his physical examination was noncontributory.

Electrocardiogram showed normal sinus rhythm with normal P waves and was otherwise unremarkable. Chest roentgenogram showed a normal cardiac silhouette (Fig. 1). Cardiac fluoroscopy revealed systolic pulsation of the right atrium.

Laboratory data included normal blood counts, normal blood urea nitrogen (BUN), and serum bilirubin of 1.9 mg per 100 ml, of which 1.1 mg per 100 ml was direct bilirubin. Other laboratory data were normal. Cardiac catheterization demonstrated a significant degree of isolated tricuspid insufficiency. The right atrial pressure tracing showed a ventricularized curve with a prominent systolic "CV" wave and very little ventriculoatrial delay (Fig. 2). The right ventricular end diastolic pressure was slightly elevated, as shown in Table 1 and Figure 2. Right ventricular cineangiogram showed a large right ventricle with a significant degree of systolic regurgitation of contrast material to an enlarged right atrium and also into the inferior vena cava (Fig. 3).

### Discussion

The first clinical case of traumatic tricuspid regurgitation was reported in 1848 by Todd.<sup>2</sup> The 20 cases subsequently reported have been recently reviewed by Jahnke, et al (1967),<sup>1</sup> Morgan and Forker,<sup>3</sup> and Croxson, et al (1971).<sup>4</sup> The typical patient with traumatic tricuspid regurgitation usually presents at a variable time after major chest trauma, in most cases secondary to an auto-

Reprint requests to Department of Cardiology, Mt. Sinai Hospital, 1800 East 105th St., Cleveland, Ohio 44106 (Dr. Edelstein).  
Submitted September 21, 1972.

mobile accident.<sup>3</sup> Minimal symptoms are present in spite of severe tricuspid regurgitation.<sup>1,3,4</sup> The tricuspid regurgitant murmur is usually soft and relatively inconspicuous compared to the murmur of tricuspid regurgitation of other etiologies.<sup>1</sup> Systolic pulsation of the jugular veins and the liver are usually the most prominent clinical findings.<sup>1,3,4</sup> Electrocardiogram usually shows incomplete or complete right bundle branch block with sinus rhythm or most frequently atrial fibrillation, in 14 out of 15 cases reviewed by Morgan.<sup>3</sup> Chest roentgenogram shows nonspecific cardiomegaly and occasionally a large right atrium.<sup>3,4</sup> Cardiac catheterization findings most of the times have included normal right ventricular end diastolic pressure<sup>1,3,6</sup> and a ventricularized atrial pressure curve with little ventriculoatrial delay between their systolic pressure curves.<sup>4,5</sup> Cineangiogram shows a large right ventricle and right atrium and the objective evidence of regurgitation.<sup>1</sup>

In our patient, the following important features are worth considering. The softness of the tricuspid murmur most probably was an important factor in the delay of the proper cardiac diagnosis. The most noticeable of all the clinical findings was the prominent systolic pulsation of the neck veins and the liver. This patient remained relatively asymptomatic and had a benign course for the past nine years, including the presence of normal sinus rhythm and a normal electrocardiogram. His chest roentgenogram also remained within normal limits and his right ventricular end diastolic pressure was only slightly elevated.

Morgan, et al<sup>3</sup> divided patients into two groups: (a) one group included patients with ruptured papillary muscle (4 out of 15 cases), and they either had surgery or promptly died; (b) the second group had traumatic tricuspid



FIG. 1. Chest roentgenogram in anteroposterior position showing normal cardiac silhouette.

TABLE 1. Right Heart Pressure

| Site                  | Pressure in mm Hg | Mean |
|-----------------------|-------------------|------|
| Right atrium          | a = 13<br>v = 23  | 12   |
| Right ventricle       | 28/8              |      |
| Main pulmonary artery | 28/10             | 17   |
| Pulmonary "wedge"     | a = 3<br>v = 12   | 9    |

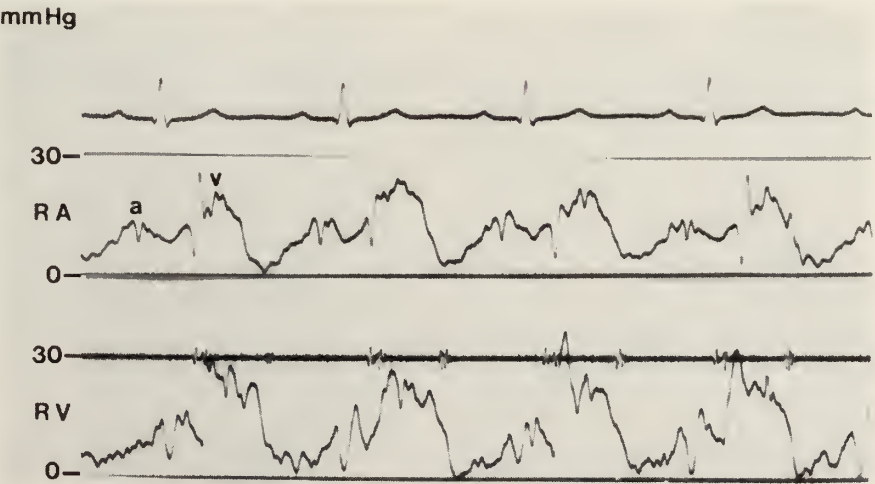


FIG. 2. Upper half, right atrial pressure showing prominent V wave (ventricularized curve). Note resemblance to ventricular pressure curve shown below. Lower half, right ventricular pressure with slightly elevated end diastolic pressure (8 mm Hg).



regurgitation due to ruptured chordae tendinae, and most of these patients had a relatively benign course. The clinical course of our patient falls into the second group. One case of traumatic tricuspid regurgitation due to rupture of the whole valve has been reported.<sup>1</sup> Cyanosis has been reported in three cases,<sup>1</sup> but it was not a feature in our case.

The benign course of the lesion has been attributed to the low pressure present in the right side of the heart in traumatic regurgitation as compared to pulmonary and right ventricular hypertension in the tricuspid regurgitation associated with most patients having the lesion on the basis of rheumatic heart disease.<sup>1,5</sup> This is also true when traumatic tricuspid regurgitation is compared to traumatic mitral regurgitation.

A clear understanding of this lesion and the awareness of its occurrence after chest trauma, accompanied by the knowledge of its benign clinical course, in most cases, is necessary in order to make a prompt and correct diagnosis.

### Summary

Tricuspid regurgitation is not a common result of chest trauma. When it occurs, most patients have minimal or no symptoms and a long-term, benign course. Physical examination reveals prominent systolic pulsations in the neck veins and the liver. A tricuspid regurgitant murmur can be heard in most instances.

We have presented one patient with a nine-year history and an uneventful course that exemplifies such a case. If this diagnosis is kept in mind, it can be made with ease. Right heart catheterization, in order to obtain right ventricular and right atrial pressures followed by cineangiograms with contrast material injected into the right ventricle, are conclusive diagnostic tests for tricuspid insufficiency. The onset of clinical findings after chest injury points toward the traumatic etiology.

In view of his benign course, our patient had no need for therapy. Some patients can be successfully treated surgically if the circumstances so require.

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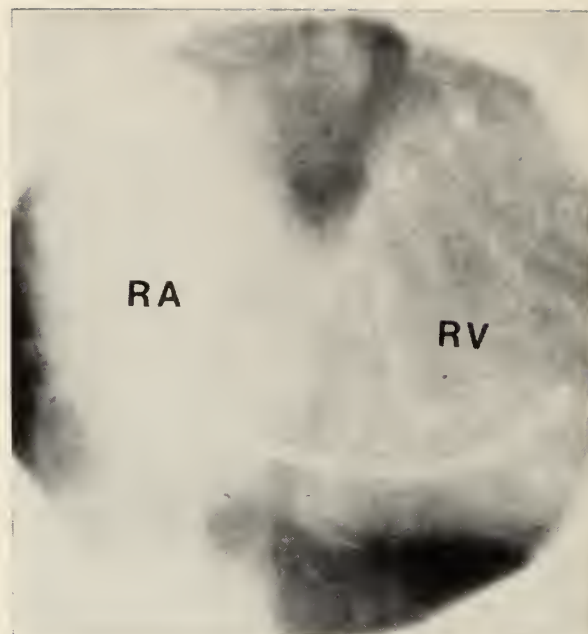


Fig. 3. Cineangiographic frame. Right ventricular injection during systole showing enlarged right ventricle and right atrium outlined by regurgitation of contrast material secondary to tricuspid insufficiency.

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# Ehlers-Danlos Syndrome Coexisting with a Martin-Gruber Anastomosis

## A Case Report

DONALD M. POSNER, M.D.

**THIS CASE IS BEING REPORTED** because of the occurrence of a relatively rare disease of connective tissue existing in an individual who also has a relatively uncommon anomaly of innervation of hand musculature. The combination of these two factors presented an unusual and initially confusing clinical picture.

This 20-year-old white male was first seen in the neurology laboratory of Akron General Medical Center in July of 1970. He was left-handed and was referred to the laboratory because of numbness involving the thumb, index, and middle fingers of the left hand, particularly after use of the left upper extremity. This was most marked in the left index finger. The presumptive diagnosis was that of a left carpal tunnel syndrome.

Nerve conduction velocities were done, using a Teca model B-2 electromyograph/synchronous stimulator, with supramaximal stimuli applied via surface electrode stimulation. The proximal points of stimulation were just above the ulnar groove for the ulnar nerve and midway up the arm at the medial aspect of the biceps brachii for the median nerve. The distal points of stimulation were in the traditional positions at the midflexor crease of the wrist for both nerves. The pick-up electrodes were surface discs applied over the opponens pollicis and over the abductor digiti quinti manus. At that time, the median latency across the carpal tunnel was 3.0 msec, which is well within normal limits for this laboratory. Stimulation of the ulnar nerve just above the elbow produced a well-formed action potential over the opponens pollicis. It was felt, therefore, that this patient had mixed innervation, (a so-called Martin-Gruber anastomosis).

### *The Author*

• Dr. Posner, Akron, is Director, Neurology Laboratory, Akron General Medical Center.

This was not completely documented, nor were photographic records made in 1970.

Upon request, the patient returned to the laboratory approximately two years later to more completely document his mixed innervation. Stimulation of his left median nerve at the midarm with pick-up electrodes over the opponens pollicis produced a conduction velocity of 52.2 meters per second (within normal limits). His left median latency across the carpal tunnel was 3.1 msec. Stimulation of his left ulnar nerve just above the ulnar groove at the elbow with pick-up electrodes over the abductor digiti quinti manus, produced an ulnar motor nerve conduction velocity of 42.0 meters per second, which was considered just at the lower limits of normal for this patient's age. The latency through his ulnar tunnel was 2.7 msec which, once again, is clearly within normal limits.

At this point, crossed stimulation was tried. When the ulnar nerve was stimulated just above the elbow, it was noted that the action potential displayed from the opponens pollicis, and then from the abductor digiti quinti manus were of roughly the same amplitude. The time required for the impulse to travel to both areas was roughly equal, if anything, it traveled a bit faster to the opponens pollicis. These findings are illustrated in



Figures 1 and 2.\* Figures 3 and 4 show similar crossed innervation when the median nerve was stimulated medial to the biceps brachii with pick-up electrodes over the opponens pollicis and the abductor digiti quinti manus. It is felt that these findings clearly prove the presence of "cross-over phenomenon" in this individual.

At the time of the last neurophysiologic testing (August 1972), cursory physical examination revealed that the patient clearly subluxed his ulnar nerve medially out of the ulnar groove upon flexion of the forearm when the forearm was held in supination. He still had similar sensory symptoms in his hand.

In the time between these two tests, the fact was called to the author's attention that this patient bears the diagnosis of Ehlers-Danlos syndrome. Numerous attempts were made to find the basis for this original diagnosis. This led to

\*In all the illustrations, large divisions along the abscissa represents 30 milliseconds in time. Intervals along the ordinate represent 200 microvolts.

the records of several local physicians, some records from the Cleveland Clinic, some information from a physician now in retirement on the West Coast, which ultimately revealed that the original diagnosis was made by Dr. W. C. Marsh, a dermatologist who had practiced in Akron until his recent death. Records obtained through the courtesy of Mrs. Marsh, indicate that Dr. Marsh first suspected the diagnosis when the patient was 8 years of age. This was done on the basis of elastic and dry skin, hyperelastic joints, and friable nails. In other words, the diagnosis was made completely on clinical grounds, as far as one can discern. I have not been able to obtain any laboratory confirmation of this diagnosis, but will attempt now to summarize some of the clinical findings found over the years, which would seem to support it.

At age 15 years, he was seen because of concern by his parents regarding asymmetry of his chest. Chest films and electrocardiogram done at that time confirmed the asymmetry and showed no other abnormality. He did complain of occa-

*(Text continued on page 459)*

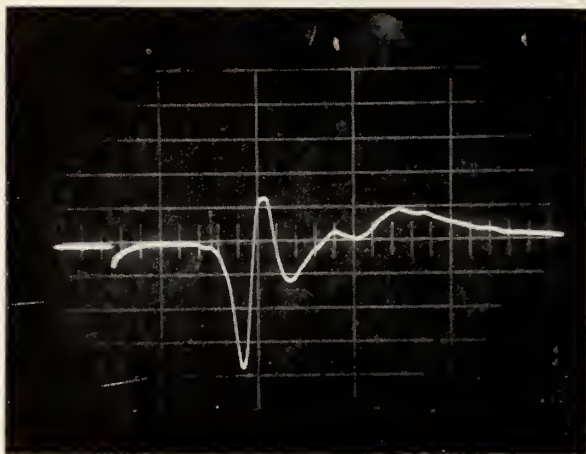


FIG. 1. Left ulnar nerve stimulated just above elbow with pick-up electrodes over abductor digiti quinti manus.

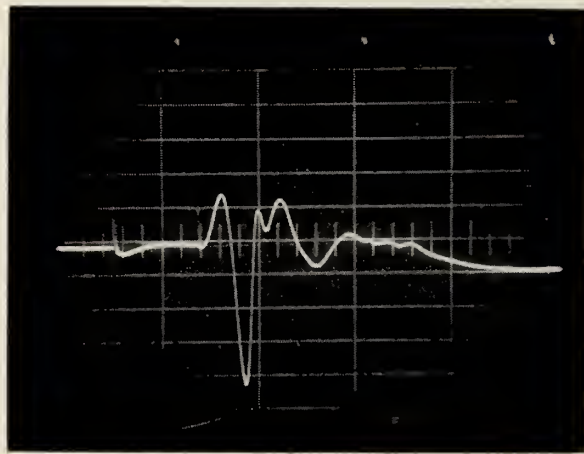


FIG. 2. Left ulnar nerve stimulated just above elbow with pick-up electrodes over opponens pollicis.

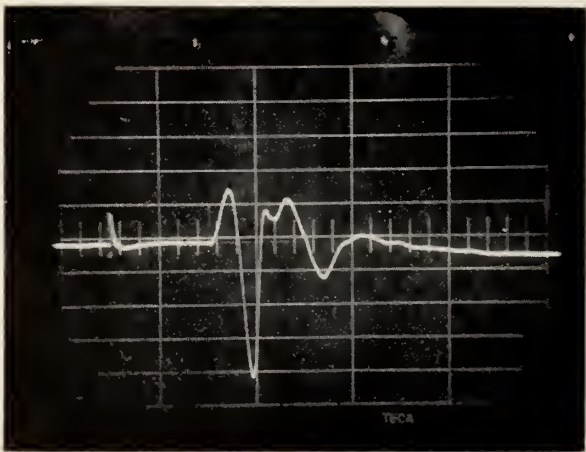


FIG. 3. Left median nerve stimulated at midportion of arm, medial to biceps brachii with pick-up electrodes over opponens pollicis.

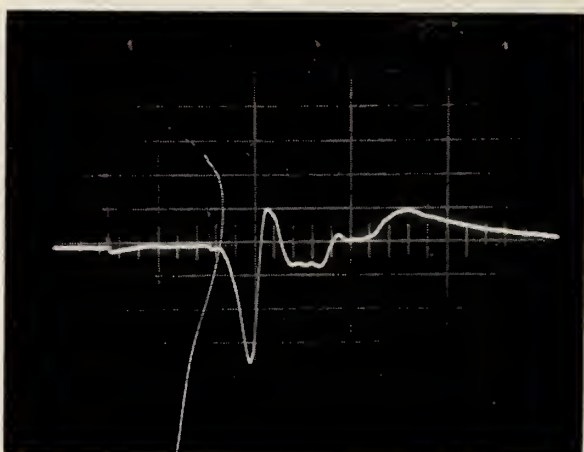


FIG. 4. Left median nerve stimulated at midportion of arm just medial of biceps brachii with pick-up electrodes over abductor digiti quinti manus.



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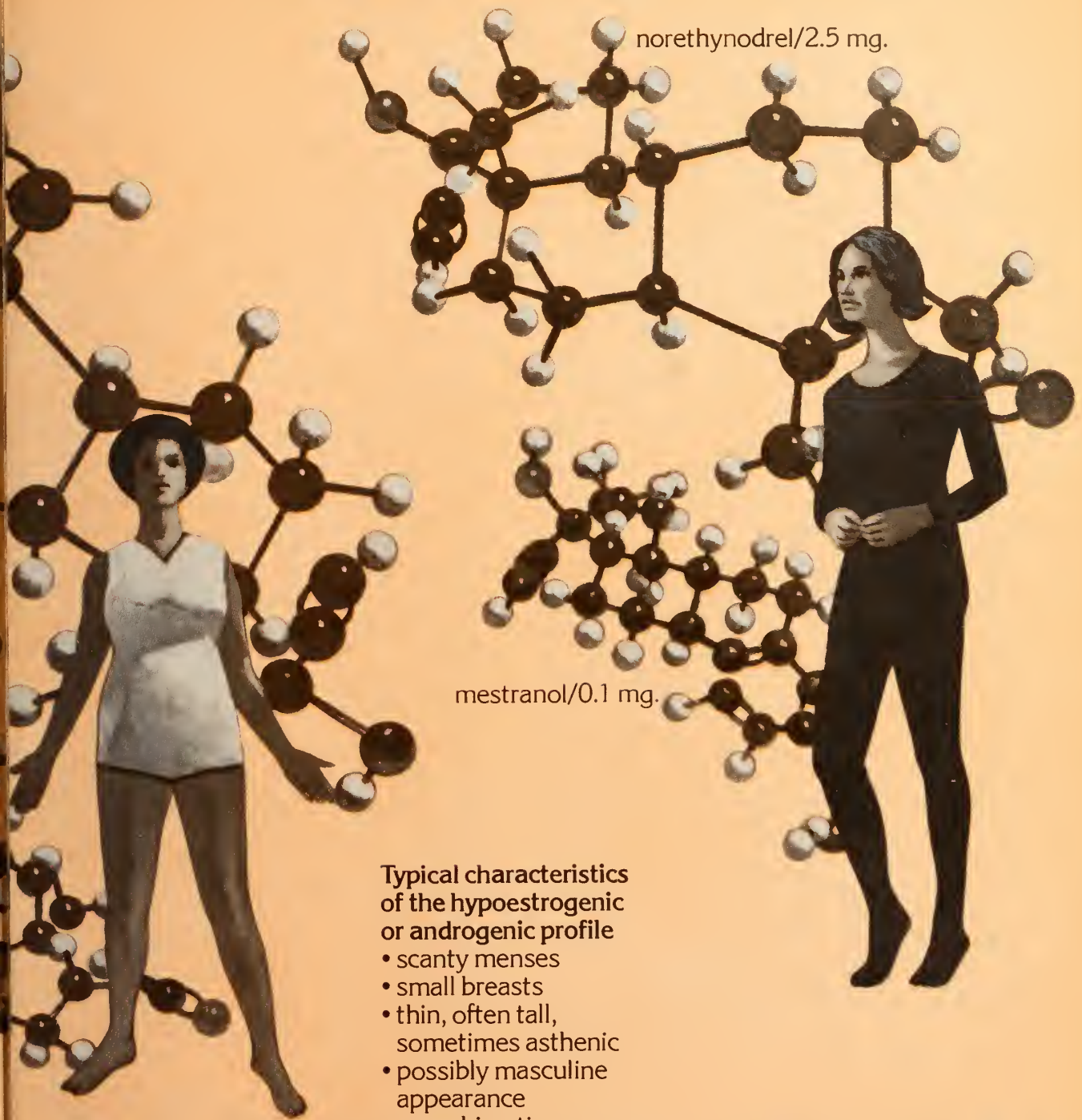
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**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1-3</sup> leading to this conclusion, and one<sup>4</sup> in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the risks are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible

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influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factor VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sup>3</sup> uptake values; metyrapone test and pregnandiol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-197 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

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sional pain, which was somewhat vague in description. He seemed to have dyspnea on moderate exertion and some difficulty keeping up physically with others his age.

When he was 16 years old, he was 6 feet 5 inches tall. He was noted to be "poorly coordinated." Physical examination at that time, revealed a depressed right anterior thorax with "sloping" ribs. The nails were pitted. There was a long, "giraffe-like" neck. The patient's arm span measured 74½ inches. From vertex to pubis, he measured 35½ inches and from pubis to floor, 44 inches.

Approximately one year later, he was seen because of attacks of syncope or near syncope frequently related to standing in the heat. He never had a convulsion of any sort. At that time, he was 6 feet 5½ inches tall and weighed 67.4 kg (148.5 lb). His chest expansion was 37½ inches on maximum inspiration, 32½ inches on maximum expiration. Blood pressure was 90/70 mm Hg. A variety of routine laboratory studies such as sedimentation rate, complete blood count, urinalysis, calcium, phosphorus, total protein, protein-bound iodine, and intravenous pyelogram, were unremarkable. An electroencephalogram was interpreted as being normal. A five-hour glucose tolerance test was felt to be somewhat suspicious of a prediabetic state, but certainly not markedly abnormal. (The values were as follows: fasting 91 mg per 100 ml, one-half hour, 156 per 100 ml, one hour 161 mg per 100 ml, two hours 125 mg per 100 ml, three hours 86 mg per 100 ml, four hours 81 per 100 ml, and five hours 89 mg per 100 ml. The patient was unable to void at anytime before or during the test.) It was also noted that he had a somewhat high, arched palate. Cardiac examination revealed a regular sinus rhythm with no cardiac enlargement. There were no murmurs or thrills. M-1 was slightly softer than M-2; A-2 and P-2 were equal. His pulse rate was 70 beats per minute and regular.

A review of this young man's past history revealed that he underwent a tonsillectomy at about 10 years of age. There is no good perinatal

history available, but it would appear that his "milestones" were normal.

A review of his family history shows only that he has a grandfather who suffered from some sort of heart disease. He has a sister approximately two years older than himself who is living and well and who is 5 feet 9 inches tall. He has a brother three years younger whose height is unknown at the present time, but at about age 13 years, the patient's brother was 5 feet 2 inches tall. His mother is 5 feet 7½ inches tall; his father is 6 feet 3 inches tall.

In summation, it would appear that a diagnosis of Ehlers-Danlos syndrome was made on the basis of body disproportion, extreme hypermobility of the patient's joints especially in the upper extremities both proximally and distally, and cutaneous changes felt to be consistent with this disease.

### Summary

This patient is being reported because of the unequivocal presence of a Martin-Gruber anastomosis which caused the patient to present with symptoms of a typical median nerve entrapment in the carpal tunnel, but which were in reality due to subluxation of the ulnar nerve at the elbow. This uncommon congenital anomaly can, by itself, present a confusing clinical picture. When it does appear, it is not necessarily (and indeed probably not usually), associated with any other pathologic process. In this individual, however, there is strong clinical evidence for a presumptive diagnosis of Ehlers-Danlos syndrome, which is felt to at least partially account for the patient's ulnar nerve subluxation, thereby contributing to the initially puzzling manifestations.

**Acknowledgement:** It is appropriate that John Schlemmer, M.D., Chairman, West Side Family Practice Center, Akron General Medical Center, be given credit for originally referring the case and for then informing me of the diagnosis of Ehlers-Danlos syndrome. Jack Mostow, M.D., Head of Endocrinology Section, Akron General Medical Center, also was of great assistance in helping me locate much of the clinical information upon which the Ehlers-Danlos syndrome was diagnosed.

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# Maternal Deaths Due to Pulmonary Embolism\*

By THE OSMA COMMITTEE ON MATERNAL HEALTH

**P**ULMONARY EMBOLISM continues to be one of the major causes of maternal death in Ohio. During the past 16 years the Committee has published six articles on this subject,<sup>1-6</sup> inviting attention of the medical public to this catastrophic complication of pregnancy and the puerperium, in an effort to reduce the incidence. Finally, the Committee designed and presented a display dealing with this problem, for the OSMA Annual Meeting, May 6-9, 1973. Members elicited numerous interesting and educational facets related to the subject, during research into the files of the Ohio Maternal Mortality Study. These will be covered briefly in this article. Needless to say, although the general number of maternal deaths in Ohio has gradually diminished in 16 years, the annual number of maternal deaths due to pulmonary embolism has NOT changed appreciably (Fig. 1).

First, the Committee presents three cases of maternal death due to embolism; one (each) will represent death due to amniotic fluid embolism, air embolism, and thromboembolic phenomenon, respectively.

## Case No. 1573

This case was a 36-year-old, white, obese, para V, abortus II, cesarian I, who died 30 minutes post partum. Previously she had had five term pregnancies, the largest baby weighing 4.5 kg (10 lb), all uncomplicated. There were two spontaneous abortions without dilation and curettement. The last pregnancy was uneventful; care was considered ade-

quate. At 42 weeks, her membranes ruptured at home on January 25. She was admitted January 26, in mild labor, cervix 2 cm, 20 percent effaced, vertex at -3 station. Labor was stimulated using Buccal Pitocin, one tablet about every 45 minutes for five doses. Moderate contractions ensued; 15 minutes after the last "pill," the nurse noted that the patient became cyanotic and convulsed. The resident physician was summoned. She was intubated immediately; bradycardia and fibrillation followed. Atropine and sodium bicarbonate were given. Defibrillation failed to improve the very slow heart beat; the patient was moribund. External cardiac massage and ventilation were continued. A classical cesarean section was performed promptly, and a large, living baby was delivered. Thoracotomy was done, adrenalin, atropine, and Isuprel were administered but the patient pursued a downhill clinical course and died.

*Cause of Death (Autopsy):* Amniotic-fluid, pulmonary embolism (bile, fetal meconium, epithelial squamæ, and "curled-up" lanugo hair were demonstrated).

## Comment

The Committee studied the case with keen interest, appreciating the completeness of the pathologist's report. The hazards of oxytocin administration are portrayed, although monitored effects of its accumulated action were not recorded. By a narrow margin, members voted this a *nonpreventable* maternal death.

## Case No. 1381

A 23-year-old married, Negro, primigravida died undelivered in the fourth month of pregnancy. No details are recorded in her past or present history. She was dead on arrival at the hospital, a rubber catheter extending from the vagina.

*Cause of Death (Coroner's Autopsy):* Attempted abortion by insertion of a rubber catheter into the uterus; air embolism; partial separation of the placenta; pregnancy, circa 4½ months gestation.

## Comment

Committee members were hampered by a lack of information concerning the patient.

They voted this a *preventable* maternal death, based upon the coroner's report.

## Case No. 1602

A 30-year-old, white, para O, cesarian III, died 4½ hours postoperative. Her past history was not remark-

\*A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

Submitted March 27, 1973.



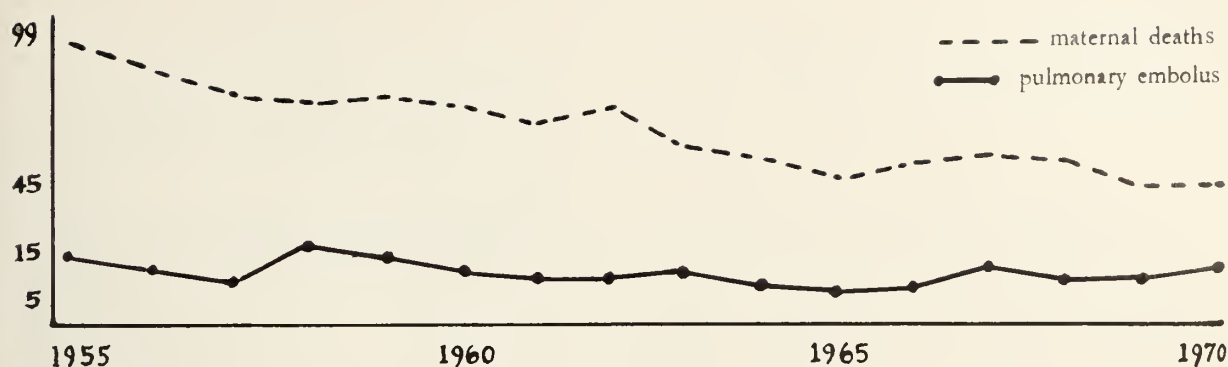


FIG. 1. Number of Ohio Maternal Deaths and Maternal Deaths Due to Pulmonary Embolism, per Year, 16 Years, 1955 Through 1970.

able; a primary cesarean section was done at term, after a trial of labor and dystocia in a breech presentation. The second cesarean at term was a "repeat" operation; neither was followed by any complication. She registered for the third pregnancy in the second month; last menstrual period was December 7. She had an uneventful course with adequate care; a slight anemia was corrected by the administration of iron. On September 8, at 39 weeks, an elective, repeat-cesarean operation was performed with spinal anesthesia, and a living, mature baby was delivered. Neither the anesthesia, the operation, nor immediate postoperative period was complicated in any way. The patient was awake and talking, in her room. Three hours postoperative, the nurse left the room to change an intravenous tube; the patient's roommate called the nurse with alarm. The nurse immediately returned to find the patient dyspneic and cyanotic, and summoned the resident physician, as the patient appeared to have a convulsion, after screaming. The emergency alarm brought many assistants, all heroic measures failed, and the patient died within the hour.

**Cause of Death (Autopsy):** Massive pulmonary embolism; thrombosis of intrauterine veins at the site of placental insertion; thrombotic occlusion of right ovarian vein; varicosities of the ovarian vein. (Squamous, epithelial cells or other particles of amniotic fluid were not observed in the thrombi.)

### Comment

Members of the Committee studied the facts in the full report with a substantial degree of amazement. After a brief deliberation, they voted the case a *nonpreventable* maternal death, unavoidable catastrophe.

### OSMA Exhibit

Various pertinent data obtained for presentation in the display are reiterated briefly. During the 16 years from 1955 through 1970, the Committee studied 1,500 cases, determining that 1094 were maternal deaths (connected directly or indirectly with the pregnant state). Primary causes of death were found to be: hemorrhage 284; infection 213; toxemia 114; and "other causes" 483 cases, respectively. Further analysis revealed (under "other causes") 195 maternal deaths due to pulmonary embolism; the three types of embolism

with number of patients (each) and percentile of autopsies are shown in Table 1.

Quite obviously, although the total number of patients is correct, the diagnosis of (either) "amniotic fluid embolism" or "air embolism" was *not* accepted in the statistics *unless* proved by autopsy; cases bearing the amniotic fluid or "air" diagnosis on the certificate (not supported by pathologic or microscopic study) were automatically placed in the remaining, "thromboembolic" group.

Of the 131 patients who died from thromboembolic pulmonary embolism, 32 (24.4 percent) died undelivered; all of the patients with air embolism (14) died undelivered; and 23 (46 percent) of those with amniotic fluid pulmonary embolism (50) died undelivered.

Further examining the group of 131 patients who suffered thromboembolic phenomenon, the interval of time between delivery and death was found to vary extensively (Table 2). Oddly

TABLE 1. Types of Pulmonary Emboli, Percentile of Autopsies, in 195 Maternal Deaths, Ohio Maternal Mortality Study, 16 years

| Type                    | No. | Autopsies % |
|-------------------------|-----|-------------|
| Air embolism            | 14  | 100         |
| Amniotic fluid embolism | 50  | 100         |
| Thromboembolic          | 131 | 66          |

TABLE 2. Interval between Delivery and Death, 131 Maternal Deaths Due to Thromboembolic Pulmonary Emboli

| Interval                  | No. of Patients |
|---------------------------|-----------------|
| Died undelivered          | 32              |
| Less than 1 hr postpartum | 5               |
| 1 to 2 hrs                | 3               |
| 2 to 6 hrs                | 10              |
| 6 to 12 hrs               | 5               |
| 12 to 24 hrs              | 3               |
| 1 to 7 days               | 26              |
| 7 to 28 days              | 36              |
| 1 to 6 months             | 9               |
| 6 months to 1 year        | 2               |

enough, the greatest single number (36) survived for from 7 to 28 days postpartum. Sixty-four patients (over half of the group) had had adequate prenatal care; 15 had a recorded history of varicosities!

### Preventability

Examining the facets connected with the preventability of 195 maternal deaths due to pulmonary embolism (all three types), only 72 (36.4 percent) were voted *preventable* (Table 3). Obviously, this is quite a "switch" from the usual; for example, in the 10-Year Survey of Ohio Maternal Deaths<sup>8</sup> the Committee voted 64.6 percent of all the 779 maternal deaths preventable, with the overwhelming majority due to personnel responsibility. Relative to pulmonary embolism, the Committee found error in judgment and/or technique an avoidable factor in only 33 of the 195 deaths;

TABLE 3. Preventability, 195 Maternal Deaths Due to Pulmonary Embolism

|                                 |     |
|---------------------------------|-----|
| Nonpreventable                  | 123 |
| Preventable                     | 72  |
| P <sub>1</sub> (Patient)        | 21  |
| P <sub>2</sub> (Personnel)      | 35  |
| P <sub>1</sub> + P <sub>2</sub> | 14  |
| P <sub>3</sub> (Misc)           | 2   |

TABLE 4. Avoidable Factors, 195 Maternal Deaths Due to Pulmonary Embolism

|                           |     |
|---------------------------|-----|
| Unavoidable catastrophe   | 123 |
| Inadequate prenatal care  | 6   |
| Patient error             | 21  |
| Induced abortion          | 10  |
| Error/judgment, technique | 33  |
| Miscellaneous             | 2   |
| (High risk patients)      | 11) |
| (Related to death)        | 2)  |

patient error and inadequate prenatal care accounted for 27 of the factors (Table 4).

### Prophylaxis

The prevention of postpartum pulmonary embolism, has been outlined sharply by Vorherr:<sup>8</sup>

1. Avoid operative delivery.
2. Prevent sepsis; treat promptly if it appears.
3. Early ambulation, leg exercises, elastic bandages, warm compresses.
4. Antisludging agents (dextran, aspirin, phenylbutazone).
5. Anticoagulants (heparin, coumarins).
6. Antibiotics and antithrombophlebitis agents (aspirin, phenylbutazone).
7. Fibrinolytic agents (human fibrinolysin, streptokinase, urokinase).

### Management

Likewise, the treatment of acute pulmonary embolism has been outlined to include:

1. Meperidine (100 mg intravenously) and atropine (1 mg intravenously) to relieve pain and anxiety.
2. Papaverine hydrochloride 15 mg in a central venous catheter, or 50 mg in an arm vein (to reduce spasms of coronary and pulmonary vessels).
3. Lidocaine 50 to 100 mg intravenously (for arrhythmias).
4. Ouabain 0.25 mg intravenously (myocardium).
5. Oxygen (100 percent) by nasal catheter or mask.
6. Sodium bicarbonate 40 to 60 mEq/liter intravenously (to correct acidosis).
7. Heparin 10,000 Units intravenously every 4 hours for 24 hours (to prevent further thrombus formation).
8. Embolectomy when patient's condition is deteriorating despite treatment.
9. Fibrinolytic therapy, streptokinase, and urokinase (alternatives for heparin treatment and embolectomy, to lyse thrombi and emboli).

### Summary

From a 16-year survey of Ohio maternal deaths, the Committee presents data related to deaths from pulmonary embolism. References outlining the prevention and management of postpartum pulmonary embolisms are cited.

### Generic and Trade Names of Drugs

Oxytocin citrate, buccal—Pitocin Citrate, Buccal (Parke-Davis)  
Isoproterenol hydrochloride — Isuprel (Winthrop Laboratories)

### References

1. Committee on Maternal Health: Maternal deaths due to pulmonary emboli. *Ohio State Med J* 53: 296-298, 1957.
2. Committee on Maternal Health: Maternal deaths involving pulmonary embolism. *Ohio State Med J* 54:1057-1059, 1958.
3. Committee on Maternal Health: Maternal deaths involving pulmonary embolism. *Ohio State Med J* 56:204-205, 1960.
4. Committee on Maternal Health: Maternal deaths involving pulmonary embolism. *Ohio State Med J* 57:172-173, 1961.
5. Committee on Maternal Health: Maternal deaths involving pulmonary embolism. *Ohio State Med J* 61:828-829, 1965.
6. Committee on Maternal Health: Maternal deaths due to air embolism. *Ohio State Med J* 68:1105-1107, 1972.
7. Committee on Maternal Health: Maternal mortality report for Ohio—a 10-year survey. *Ohio State Med J* 63:323-332, 1967.
8. Vorherr H: Management of Puerperal Problems and Complications in *Davis' Gynecology and Obstetrics*, Hagerstown, Harper & Rowe, 1972, pp. 19-28.

# Discussion of E.N.T. Case of the Month

*(continued from page 444)*

These signs and symptoms are classic for a patient with acute mastoiditis, a condition rarely seen today. When it occurs, it usually is the result of untreated or incompletely treated otitis media. In this instance, the five-day course of antibiotic therapy was not sufficient to eradicate completely the infection in the middle ear cleft.

The diagnosis can be made by radiographic examination of the mastoids. In acute mastoiditis, there will be clouding of the mastoid air cells and more importantly, loss of the bony septae which separate the mastoid air cells (Fig. 1). The latter finding makes the diagnosis of acute mastoiditis, since "clouding" of the air cells alone is a non-

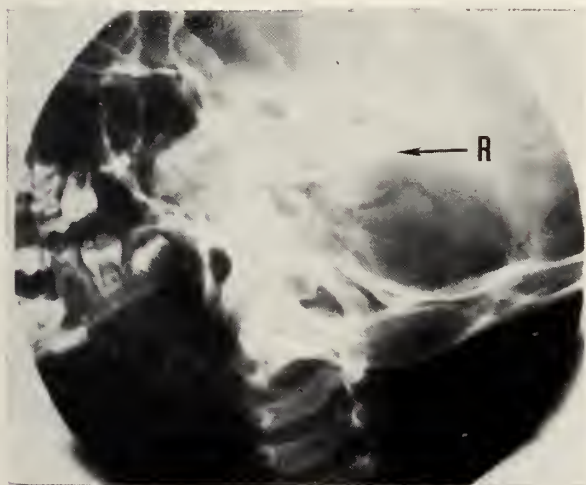


FIG. 1. Diagnosis of acute mastoiditis is made by radiographic evidence of clouding and loss of separation of mastoid air cells giving the mastoid a "ground glass" appearance.

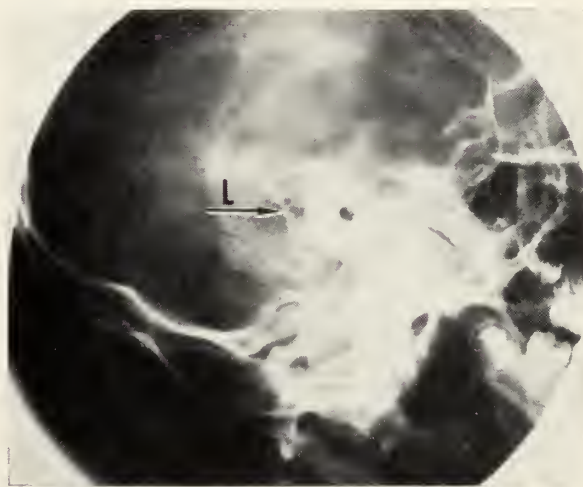


FIG. 2. Normal left (L.) mastoid. Note preservation of bony septae between air cells.

specific finding occurring with uncomplicated otitis media or serous otitis media.

When the diagnosis of acute mastoiditis is made, aggressive therapy should be started immediately, since this condition is associated with a high incidence of intracranial complications.

The initial treatment should consist of a wide myringotomy, culture and sensitivity of the drainage, and the appropriate antibiotic in high dosage.

Most of the patients will improve within 48 hours; if no improvement is noted, then a simple mastoidectomy operation should be done. During this procedure, the outer bony cortex of the mastoid is opened, the granulation tissue is removed, and a drain is placed in the wound. In essence, the operation simply drains an abscess cavity. Simple mastoidectomy usually leaves the patient with no postoperative sequelae (Fig. 2).



# Change the AMA!

Maybe you're one of those doctors at odds with some AMA policies. Your question is: how do you change them?

First, consider who sets those policies. In a real sense, it is you. You elect the delegates to your state association. They in turn elect the delegates who will represent your views in the AMA House.

As an active, involved member, you can influence policy by making your views known to your delegates, both national and state. It is your democratic right — and responsibility.

Write your delegates, call them, see them. If they aren't responsive, tell them they'll be hearing from you at election time.

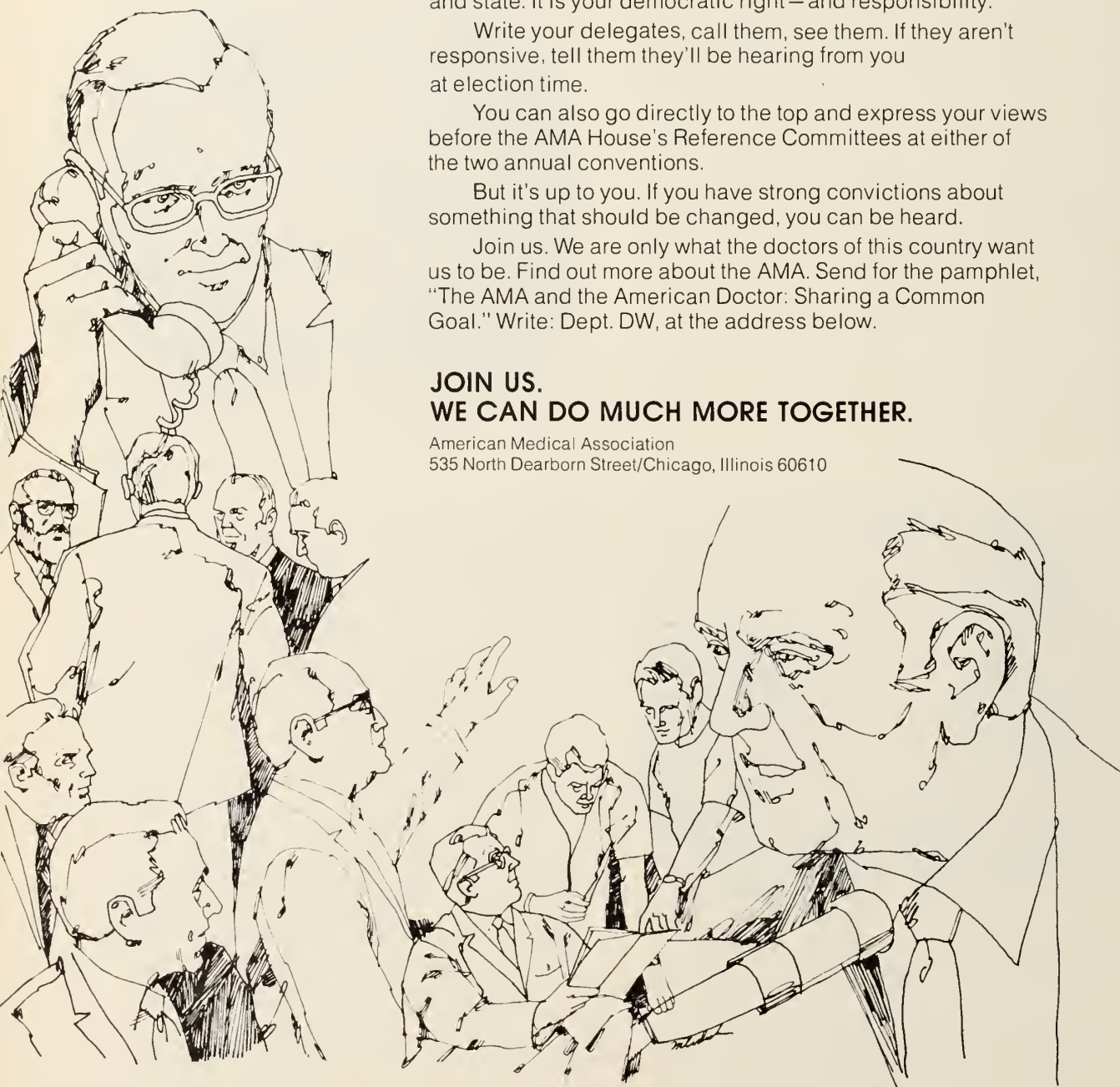
You can also go directly to the top and express your views before the AMA House's Reference Committees at either of the two annual conventions.

But it's up to you. If you have strong convictions about something that should be changed, you can be heard.

Join us. We are only what the doctors of this country want us to be. Find out more about the AMA. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

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American Medical Association  
535 North Dearborn Street/Chicago, Illinois 60610



# Officers and AMA Delegates Elected at the 1973 Annual Meeting

Dr. OSCAR W. CLARKE, of Gallipolis, was installed as President of the Ohio State Medical Association, at the final session of the House of Delegates on May 9 during the OSMA Annual Meeting in Columbus. He was named President-Elect of the Association at the 1972 Annual Meeting in Cincinnati after serving since 1966 on The Council as Councilor of the Ninth District.

Dr. James L. Henry, Grove City, was named President-Elect and will succeed to the Presidency at the 1974 Annual Meeting in Cleveland. He has served six years on The Council as Treasurer and Secretary-Treasurer.

Dr. William M. Wells, of Newark, was elected Secretary-Treasurer for a three-year term. Dr. Wells has served on The Council since 1967 as Councilor of the Eighth District.

Dr. Richard E. Hartle, of Lancaster, was elected Councilor of the Eighth District to succeed Dr. Wells. Dr. Hartle has served several terms as delegate from the Fairfield County Medical Society to the OSMA House of Delegates and is currently serving as vice-president of the County Society.

Dr. James G. Tye, Dayton, was reelected Councilor of the Second District.

Dr. George N. Bates, Toledo, was reelected Councilor of the Fourth District.

Dr. Maurice F. Lieber, Canton, was reelected Councilor of the Sixth District.

Dr. James C. McLarnan, Mt. Vernon, was reelected Councilor of the Tenth District.

Councilors in the midst of two-year terms are the following: Dr. Stephen P. Hogg, Cincinnati, First District; Dr. John C. Smithson, Findlay, Third District; Dr. David Fishman, Cleveland, Fifth District; Dr. Robert E. Rinderknecht, Dover, Seventh District; Dr. Thomas W. Morgan, Gallipolis, Ninth District; and Dr. Robert G. Thomas, Elyria, Eleventh District.

Dr. William R. Schultz, Wooster, will serve an additional year on The Council as Immediate Past President.

Dr. P. John Robeck, Cleveland, has retired from The Council after serving since 1964, as Councilor of the Fifth District, President-Elect, President and Past President.

The House of Delegates reelected the following Delegates to the American Medical Association for additional two-year terms beginning January 1, 1974: Dr. Oscar W. Clarke, Gallipolis; Dr. Henry A. Crawford, Cleveland; Dr. Harry K. Hines, Cincinnati; and Dr. P. John Robeck, Cleveland.

Dr. William J. Lewis, Jr., Dayton, Alternate Delegate, was elected Delegate for two years to succeed Dr. Frederick P. Osgood, Toledo, who was not a candidate for reelection.

Delegates in the midst of two-year terms are the following: Dr. Richard L. Meiling, Columbus; Dr. Lawrence C. Meredith, Oberlin; Dr. Robert N. Smith, Toledo; and Dr. Robert E. Tschantz, Canton.

The following Alternate Delegates were reelected for two-year terms beginning January 1, 1974: Dr. George N. Bates, Toledo; Dr. Richard L. Fulton, Columbus; Dr. Jerry L. Hammon, West Milton; and Dr. Jack Schreiber, Canfield.

Dr. William R. Schultz, Wooster, was elected an Alternate Delegate for a two-year term beginning January 1, 1974 to succeed Dr. Lewis.

Dr. Bernard L. Huffman, Jr., Toledo, was elected an Alternate Delegate for the remainder of the term of Dr. Robert P. Johnson, Middletown, who resigned. The term ends December 31, 1974.

Alternate Delegates in the midst of two-year terms are the following: Dr. Dwight L. Becker, Lima; Dr. David Fishman, Cleveland; and Dr. H. William Porterfield, Columbus.

Because of the time element involved, only this brief summary of election results could be included in this issue of *The Journal*. Watch for the July number and complete reports of the 1973 Annual Meeting, including official minutes of the House of Delegates.

## State Association Past President Dies

Horatio Thomas Pease, M.D., practitioner of long standing in Wadsworth, Past President of the Ohio State Medical Association, and former Alternate Delegate to the American Medical Association, died on April 30 at the age of 72.

Dr. Pease served as President of the State Association in 1963 and 1964. He had previously served three full terms on The OSMA Council as Councilor of the Eleventh District, and was later elected an Alternate Delegate to the American Medical Association.



H. T. Pease, M.D.

His dedicated general practice in a non-metropolitan area of Ohio and his devotion to the needs of his patients fitted well into the pattern of his life which began with a typical American flavor. He was born in a log cabin on a modest farm in Georgia, followed the missionary trails of his father which took him as a child to the far northern reaches of Norway, and pieced together his early education in the schools of at least three states. After serving in the Army during World War I, he studied at Bethany College and received his A. B. degree from West Virginia University in 1922.

In 1926 he entered (Case) Western Reserve University School of Medicine with four years of high school teaching experience, a wife and child.

He received his M.D. degree in 1930, and took intern and residency training at the University Hospitals in Cleveland. Why did he pick Wadsworth as a place to practice? He told the

story that he and his wife were driving through Wadsworth one day, took a liking to the community, and decided to settle there. Depression day practice was not overly demanding, and he found time to take postgraduate courses at Harvard, the University of Michigan and the University of Buffalo. During World War II he entered his second tour of active duty with the Army, this time in the Medical Corps.

Long a member of Medina County Medical Society, he served that organization in many capacities, filling the offices of president, secretary-treasurer and delegate to the OSMA. He also was an associate member of the neighboring Summit County Medical Society, and a member of the Ohio Academy of Family Physicians. Before being elected to The Council of the Ohio State Medical Association, Dr. Pease served on the OSMA Committee on Rural Health and the OSMA Advisory Committee to the Woman's Auxiliary.

As OSMA President, Dr. Pease worked tirelessly on behalf of Ohio Medicine, serving on various committees, attending meetings throughout Ohio, filling speaking engagements, and visiting professional groups in neighboring states.

He was a leader in his own community, served as chief of staff of the Wadsworth Municipal Hospital and as a member of its Board. In addition, he was a churchman, Rotarian, Mason, Legionnaire, and fraternity man. He is survived by his wife Grace and his daughter Mary Lois who is married to David H. Stansbery, Ph.D. There are four grandchildren.

**Gedeon Asatiani, M.D.**, North Olmsted and Cleveland; medical degree from the University of Munich, 1950; aged 55; died April 17; member of OSMA, AMA, and the American Society of Abdominal Surgeons; diplomate, American Board of Surgery; native of the Ukraine; practitioner in the Greater Cleveland area for about 13 years, specializing in general surgery.

**Rodolfo Sanchez Avalos, M.D.**, Ironton; Faculty of Medicine, University of Mexico, 1953; aged 49; died April 14; member of OSMA, AMA, and the American Society of Abdominal Surgeons; practicing physician and surgeon in the Ironton area since 1962.



**Paul H. Bade, M.D.**, Chagrin Falls; Ohio State University College of Medicine, 1946; aged 60; died April 11; member of OSMA and AMA; practitioner for a number of years in the Maple Heights area of Cleveland, specializing in obstetrics and pediatrics; served as medical officer in the U. S. Air Force from 1954 to 1956.

**Walter Ching-Chi Chen, M.D.**, Youngstown; Tung Chi University Medical School, Shanghai, 1948; aged 47; died April 3; member of OSMA, AMA, American Society of Anesthesiologists, and the International Anesthesia Research Society; diplomate, American Board of Anesthesiology; anesthesiologist in Youngstown and associated with St. Elizabeth Hospital since 1958; served in the U.S. Army Medical Corps, 1956-1957.

**Alva Dean Cook, M.D.**, Dayton; Western Reserve University School of Medicine, 1917; aged 85; died March 23; member of OSMA, AMA, and the American Academy of Family Physicians; opened his practice in Dayton in 1927 after serving as a medical missionary in China and the Philippines; general practitioner in Dayton until his retirement.

**Roy Camillas Costello, M.D.**, East Liverpool; University of Pennsylvania School of Medicine, 1931; aged 68; died April 18; member of OSMA, AMA, American Society of Abdominal Surgeons, and American Geriatrics Society; practicing physician in the East Liverpool area since 1933; former deputy coroner, Columbiana County, and former director City Hospital laboratory; also former city health commissioner; past president of the Columbiana County Medical Society.

**Jose Angel deCardenas, M.D.**, Canton; University of Havana Faculty of Medicine, 1945; aged 56; died April 17; member of OSMA and AMA; native of Cuba and resident of this country since 1959; practitioner in Canton for about 12 years, specializing in anesthesiology.

**Byrne DeWeese, M.D.**, Kent; Kansas City University of Physicians and Surgeons, 1941; aged 59; died April 12; member of AMA through previous state affiliation; formerly practiced in Pittsfield, Mass.; recently associated on part-time basis with Kent State University Health Service. Dr. DeWeese was one of a family of physicians. His father was the late Dr. Arville O. DeWeese, of Kent. Two physician brothers survive, Dr. Marion S. of Columbia, Mo., and Dr. James of Rochester, Minn.

**Joseph Kannaly Doran, M.D.**, Cleveland and Chagrin Falls; University of Iowa College of Medicine, 1938; aged 59; died April 9; member of OSMA and the American Society of Internal Medicine; practitioner of long standing in the Cleveland area, specializing in internal medicine; assistant clinical professor at Case Western Reserve; served in the Army Medical Corps during World War II.

**George Lawrence Evans, M.D.**, Mansfield; Western Reserve University School of Medicine, 1932; aged 67; died April 9; member of OSMA and AMA; Fellow, American College of Surgeons and American College of Obstetricians and Gynecologists; diplomate, American Board of Obstetrics and Gynecology; practitioner in Mansfield for most of his professional career; served in the Army Medical Corps during World War II.

**Harry Lacroix Fry, M.D.**, Boynton Beach, Fla.; University of Cincinnati College of Medicine, 1931; aged 67; died April 7; member of OSMA and AMA; practicing physician and surgeon in Cincinnati until about 1968.

**Sherman R. Hawley II, M.D.**, Vero Beach, Fla.; University of Cincinnati College of Medicine, 1931; aged 70; died April 3; former member of OSMA and the Aerospace Medical Association; former private practitioner in Toledo; retired as chief of surgery at the Chillicothe VA Hospital in 1966.

**Hobart Gilmore Higginbotham, M.D.**, Cincinnati; University of Louisville School of Medicine, 1924; aged 76; died April 4; member of OSMA and AMA; practicing surgeon of long standing in Cincinnati; veteran of World War I.

**Nicholas H. Holmes, M.D.**, Chillicothe; Harvard Medical School, 1940; aged 58; died April 20; member of OSMA and AMA; Fellow, American College of Surgeons; native of Chillicothe and practicing surgeon there for many years; noted athlete during his younger years; former mayor of Chillicothe; served in the Army Medical Corps during World War II.

**Louis N. Katz, M.D.**, Chicago, Illinois; Western Reserve University School of Medicine, 1921; aged 75; died April 2; former member of OSMA; practitioner in Cleveland until about 1930 when he moved out of the state.

**Jack Gordon Miller, M.D.**, Alliance; Emory University School of Medicine, 1940; aged 57; died March 31; member of OSMA and AMA; Fellow, American College of Surgeons; diplomate,



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(1) The onset of action of T<sub>4</sub> is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)<sup>1</sup>; (2) since SYNTHROID contains only T<sub>4</sub>, the potential for metabolic surges traceable to more potent iodides (T<sub>3</sub>) is eliminated.

| TEST                      | HYPOTHYROID               | SYNTHROID THERAPEUTIC NORMAL |
|---------------------------|---------------------------|------------------------------|
| P.B.I.                    | Less than 4 mcg %         | 6-10 mcg %                   |
| T <sub>4</sub> By Column  | Less than 3 mcg %         | 7-9 mcg %                    |
| T <sub>3</sub> (Resin)    | Less than 25%             | 27-35%                       |
| T <sub>3</sub> (Red Cell) | Less than 11%             | 11.5-18%                     |
| Free Thyroxine            | Less than 0.7 nanograms % | 0.7-2.5 nanograms %          |
| Murphy-Pattee             | Less than 2.9 mcg %       | 4-11 mcg %                   |



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The conversion has been experimentally demonstrated during the administration of  $T_4$  to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, in the presence of  $T_3$  in these patients has been clearly shown.

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Very simple.  $T_3$  costs more to make synthetically than does  $T_4$ . So it is economically necessary for a synthetic thyroid medication containing  $T_3$  to cost more than one containing  $T_4$  alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID<sup>3</sup> because the  $T_3$  costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine ( $T_4$ ) to Triiodothyronine ( $T_3$ ) in Athyrotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) for Injection is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

**Precautions:** As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

**Contraindications:** Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

**Dosage and Administration:** The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

**Supplied:** Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for Injection may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.



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American Board of Obstetrics and Gynecology; practitioner in Alliance since 1956; served as flight surgeon with the U. S. Air Force during World War II and again in 1955 and part of 1956.

**Edwin D. Richards, M.D.**, Bay Village and Lakewood; Harvard Medical School, 1932; aged 66; died April 14; member of OSMA and AMA; Fellow, American College of Surgeons and American College of Obstetricians and Gynecologists; diplomate, American Board of Obstetrics and Gynecology; native of Cleveland and practitioner in the Lakewood area since the late 1940's; served as a medical officer in the U.S. Navy during World War II.

**Francis Ernest Rosnagle, M.D.**, London; Starling Medical College, Columbus, 1914; aged 87; died April 17; member of OSMA and AMA; practitioner in the London area for virtually all of his professional career; former Madison County health commissioner; physician for the London Correctional Institution; past president of the Madison County Medical Society; veteran of World War I.

**Alfred Clyde Ross, M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1929; aged 68; died February 13; member of OSMA, and AMA; Associate Fellow, American Proctologic Society; practitioner of long standing in Cincinnati and a founding member of the Cincinnati Proctologic Society; served in the Army Air Corps during World War II.

**Lester Whitlock Sanders, Sr., M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1928; aged 76; died March 5; member of OSMA, the AMA, American Academy of Occupational Medicine, and the Industrial Medical Association; diplomate, American Board of Preventive Medicine; practitioner in preventive industrial, and research medicine; member of the faculty of the University of Cincinnati College of Medicine.

**Howard A. Searl, M.D.**, Cuyahoga Falls; George Washington University School of Medicine, 1925; aged 75; died April 12; former member of OSMA; practitioner in Cuyahoga Falls until 1942 when he entered the Army Medical Corps; after the war, he became associated with the Veterans Administration, retiring in 1960.

**David Shapira, M.D.**, Youngstown; University of Vienna Medical School, 1927; aged 75; died April 13; member of OSMA, AMA, Academy of Psychosomatic Medicine, American Psychiatric Association and American Physicians Fellowship; came to this country in the late 1940's and began practice in Youngstown in 1956, where he specialized in psychiatry.

**Samuel Harold Winston, M.D.**, New Philadelphia and Dover; Queens University Faculty of Medicine, Canada, 1929; aged 67; died April 16; member of OSMA and AMA; practitioner of long standing in the New Philadelphia-Dover area where he specialized in the EENT field.

*(See additional obituary on page 475)*



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# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

THE AMERICAN AUTHOR O. Henry dubbed it "Bagdad on the Subway". More than forty odd of his short stories were written against the New York City background. Not the New York of today, of course—not the New York where the fifty-first annual convention of the Woman's Auxiliary to the American Medical Association will be held June 24-28 at the Waldorf-Astoria Hotel.

Speaking of the Waldorf-Astoria, do many of you know that in O. Henry's day, and for some two decades thereafter, the brownstone Waldorf typified an era of elegance at the corner of 34th Street and Fifth Avenue, where the Empire State Building now stands? Much has changed in the City of New York, and yet some of what O. Henry wrote in echoing its voice and expressing its moods has not entirely disappeared. It is still the nation's No. 1 metropolis and it still has a fascination all its own.

This year's convention will feature a "Backstage at the Waldorf"—a behind-the-scenes tour of the famous hotel's kitchens and a demonstration by Chef Decorator Richard Blaisdell. And, for the first time, a theatre-supper party is being offered to AMA Woman's Auxiliary members and guests. There will be the opportunity to see an outstanding Broadway show and then enjoy an after-theatre supper at a world-renowned exciting restaurant, such as Sardi's or the "Benihana Palace," an exotic Japanese Steak House. There is a choice of shows: "Sugar," "Finishing Touches," "A Little Night Music" or "The Prisoner of Second Avenue."

The auxiliary's formal opening of its House of Delegates and attendant business session will be at 9 a.m. Monday morning, June 25. Earlier that morning (at 7:30 a.m.!) the traditional Ohio breakfast will be held for delegates, alternates and honored guests. This is always a very special "moment" at the national convention.

Harry Schwartz, author of *The Case for American Medicine* and member of the *New York Times* editorial board, will speak during the Monday meeting. Dorothy Sarnoff, director of Speech Dynamics, Inc., and author of *Speech Can Change Your Life* will be the speaker at the Tuesday luncheon. Another eminent speaker will be Carl A.

Hoffman, M.D., AMA President. Important by-laws revisions will be presented for action by the delegates.

The auxiliary is also offering, through the services of Gulliver's Trails, a sightseeing and entertainment program for young people attending the AMA meeting in New York with their parents. Gulliver's Trails is planning three days of sightseeing and one night of activities that includes dinner and a film for pre-teens and a dinner and theatre party for older youth.

And so it will be "east side, west side, all around the town" for those lucky enough to be on the scene of this year's annual convention of the AMA and its Woman's Auxiliary. Welcome to the sidewalks of New York!

## Community Health Services

Mrs. Albert May, of Marion, is chairman of community health services for the state. She recently attended, along with Mrs. Louis Loria, state president, what was called the "Quality of Life Congress II" in Chicago. This is the second such Congress sponsored by the American Medical Association in cooperation with 48 other professional, voluntary and governmental agencies.

Congress II concentrated on the middle years—early adulthood, mature adulthood and the later years—of the continuance of life within a social environmental and educational frame of reference. Mrs. May said that it was described as an unknown, uncharted period.

Hugh Downs, former host of the Today Show, was the keynote speaker. Other speakers included: Seward Hiltner, Ph.D., Princeton Theological Seminary; Pauline Bart, Ph.D., assistant professor of sociology; Dana Farnsworth, M.D., vice-chairman, National Commission on Drug Abuse; William Masters, M.D., and Virginia Johnson, Ph.D., of the Reproductive Biological Research Foundation; Bernice Newgarten, Ph.D., Professor of Human Development, University of Chicago; representatives from the Xerox Corporation, the Gillerman and Kay Corporation, the UAW, the American Management Association, McCaffery, Seligman and von Simson, Inc. and Parents Without Partners; Lee Salk, M.D., direc-



tor, division of pediatric psychology, New York Hospital; Edmund Casey, president, National Medical Association.

Mrs. May comments: "It was the aim of this Congress to plan ways of overcoming human blights, of nurturing humanness and of promoting productivity, happiness and health in the Middle Years . . . it was recommended that every community be mobilized for action that will require sustained inter-group effort of the private and public sectors at the national, state and local levels. . . ."

It was the consensus of opinion that "the professions, the government, business and industry have a big stake in improving the Quality of Life during the Middle Years because it is the quality of people's lives which determines the economic and political future of America."

Ingrid May has provided me with a raft of interesting and vital material relative to the work of her community health service committee. It is my hope during the coming months to give you a bird's-eye-view of an action project under most capable leadership.

### Nutrition—The Key

Mrs. Robert E. Krone, state nutrition chairman, recently appeared on a panel presentation of a nutrition education workshop sponsored by the American Red Cross in Cincinnati. Mrs. Krone's presentation highlighted food information, teaching aids and reliable sources. Also on the panel was Fran's husband, Dr. Krone, who discussed nutrition problems as seen in a family physician's office.

The afternoon sessions (the whole program took place at the University of Cincinnati Faculty Club) featured small group question-and-answer periods relating to pediatric nutrition, general nutrition, budget problems, geriatric nutrition, teenage nutrition and special diets. Each of these discussion sessions was led by a registered dietitian who is a specialist in the field indicated. Participants moved from one group to the next, spending ten to fifteen minutes in each area. Leaders had visual materials and "hand-outs."

There was a general display that recommended books on general nutrition, some that were not recommended and several pamphlets and posters. Each participant was given a list of good references and a copy of the new Blue Cross booklet *Food and Fitness*. Invitations had been sent to Red Cross nurses, instructors, social workers—all those who need basic nutrition information for working with clients, classes or the public. Coordinator of the nutrition education workshop was Mrs. Carl F. Schilling, chairman of the Red

cross Nursing and Health Program and an outstanding member of the Hamilton county auxiliary!

### "Anatomy of Fashion"

And speaking of the Hamilton auxiliary, this year's recent style show (it's an annual event) was a bit more extra-special in that the group had a New York designer showing her clothes for the first time in Cincinnati (through the cooperation of Mabley and Carew). Miss Evelyn DeJonge, designing for Contempra, displayed a preview of her fashions and explained the development of a fashion line. Her fashions are for the "young at heart" woman who wants fresh, simple and easy to care for clothes. Miss DeJonge's fabrics are predominantly small prints and designs in easy care combinations.

A social hour and luncheon preceded the "Anatomy of Fashion" which was held at the Riverview-Quality Inn in Covington, Kentucky. Proceeds from this annual event are earmarked for the auxiliary's Philanthropy Fund which supports a wide range of service activities—from nurse scholarships, Project Hope and local service agencies to the "Apple Tree," the auxiliary's non-profit day care center for the children of key hospital personnel.

Mrs. Thomas Werner was chairman and Mrs. Robert Gregory, cochairman, of this year's show. Mrs. Denis Cash served in an advisory capacity. Other committee chairmen included: Mrs. John Popken, Mrs. John Maier, Mrs. Stephen Lewis, Mrs. Earl Van Horn, Mrs. Joseph Sirkin, Mrs. Ernest Meese, Mrs. Theodore Stone and Mrs. Robert Slagle.

### Around the State

The Jefferson County auxiliary is busy, busy, busy! In looking over the group's April newsletter, I couldn't help but be impressed at the wide range of its activities. There was the luncheon in February at the home of Mrs. J. W. Metcalf at which Mrs. J. Yobbagy served as chairman and was assisted by Mrs. J. Mantica, Mrs. A. Sunseri, Mrs. K. Rea, Mrs. J. Trupovnieks, Mrs. D. Myers, Mrs. E. Gamble and Mrs. H. Vaughn.

Then there was the Doctors' Day dinner on March 31 at the Steubenville Country Club whose chairman was Evelyn Valuska. She was assisted by Mrs. P. Mastros, Mrs. J. Smarrella, Mrs. E. Rosenblum, Mrs. C. Metzger and Mrs. N. Terezis. Following the dinner, the group moved on to the home of Dr. and Mrs. Metzger for the special dessert baked by the auxiliary members. Entertainment for the evening took the form of a group sing-a-long with music provided by a guitarist.

The farm of Dr. and Mrs. J. Current in Kilgore set the scene for an evening of "stomping



feet"—a rollicking Square Dance. There were delectable refreshments. What was much in evidence on the part of the women was the flat heel shoe (which had been strongly suggested!) All in all, it was a wonderful evening for relaxation.

The Jefferson members held a Medical Emergency Health Service night on May 9 in St. Agatha Hall. Dr. Metzger conducted a demonstration of emergency first-aid techniques. A Garage Sale was held on May 19 at the home of Mrs. Barry Greenhouse to which items were donated by the membership. Reggi Sunseri (state board member) was chairman of the day's money making activity. There was a luncheon in April at the Steubenville Country Club, with Mrs. Greenhouse serving as chairman. Jackie Strovilas has been busy collecting children's clothing from auxiliary members for the County Children's Home. May 23 was a very special day—Jefferson's twenty-fifth anniversary celebration.

And that celebration included the installation of new officers for the 1973-74 year: Dorrie Current, president; Mildred Mikita, president-elect; Evelyn Valuska, vice-president; Mary Thoma, treasurer; Sara Agresta, corresponding secretary; and Dani Manalac, recording secretary. And even into June, the "social whirl" continues. There's to be a family picnic at the home of Dr. Macedonia's mother.

What impresses me so much about the Jefferson county auxiliary is the number of social activities shared by the doctors and their wives that are auxiliary-sponsored!

#### Here and There

Noteworthy "tidbits" from **Summit County**: More than \$23,730.00 has been made available to deserving applicants by the Betty Dobkin Nursing Scholarship Committee in its twenty-one years of existence. . . . the group's Mobile Meals program is now two years old, close to 26,000 meals have been served to approximately 350 clients and a secretary has been hired to handle the daily office responsibility and there is a new, larger office thanks to the doctors at 656 W. Market Street in Akron. Not too long ago, Summit had a "Las Vegas Gala" which drew over 310 society and auxiliary members and guests and netted a profit of \$2,488.21 for Mobile Meals. The group's March meeting was a provocative affair with guest speaker Doug Adair, anchorman for WKYC-TV 3's NEWSDAY who offered the challenge "TV And You Ladies." The occasion also honored Summit's past presidents. Scene of the happy activity was the Hilton Inn West where cocktails and luncheon were served and election of officers for the 1973-74 year was held. (Unfortunately,

—an everyday

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I do not have those names as of now, but hopefully they'll be coming my way shortly. . . .)

"Butler Billboard", **Butler County's** pithy newsletter, reveals an interesting March luncheon meeting at which John Chasteen was the guest speaker. The meeting was held at the "Steak and Kettle East", as intriguing a name for a restaurant as I've ever heard! Members of the Keely Dental Society auxiliary were the guests of the medical auxiliary. The Butler group has given subscriptions to *Today's Health* to all area schools and hospitals. Nice going!

#### Elsewhere Too

**Lucas County's** "A Salute to Spring" was heralded at the New Sheraton Westgate in Toledo on April 10. It was a delightful afternoon of delicious food, exciting fashions and the ever challenging game of bridge. The gourmet luncheon was by the Master Chefs and the fashions were from Rochelle's. There were door prizes, a raffle and a social hour—in short, everything for a fun-filled day. Best of all, the "Salute to Spring" was for the benefit of AMA-ERF.

**Scioto County's** April meeting was a tea at the home of Dr. and Mrs. Jack MacDonald. Guest speaker was James Donaldson, administrator of Mercy Hospital, who described the hospital's new cardiac care unit just recently opened up.

**Tuscarawas County** has a new project in cooperation with the Dover-New Philadelphia Church Women United—Mobile Meals. The first day of operation was in January when hot lunches were packaged, transported and served to 13 persons. Since then, the figure has been "upped" and the number of volunteers has grown. Mrs. Joseph Hamilton, president of the Tuscarawas group, is

also president of Mobile Meals. Another officer of the Meals Program is Mrs. Robert Hastedt who is serving as vice-president of public relations and is an auxiliary member and a past president of the Tuscarawas auxiliary. Mrs. Herbert Van Epps, past local and state auxiliary president, is another actively working in the Mobile Meals program.

The **Washington County** auxiliary was hostess at a luncheon meeting in April for the eighth district at the Lafayette Motor Hotel in Marietta. Mrs. Arch Jones, Jr., president of the local group, introduced the honored guests: Mrs. Louis Loria, state president; Mrs. Karly Ulicny, state president-elect; Mrs. Carl Frye, 8th district director; Mrs. S. L. Meltzer, state publicity chairman and state past president; Mrs. B. U. Howland, 9th district director; Mrs. Joseph Barker, president-elect, and Mrs. Fred Karaffa, first vice-president, Licking county; Mrs. Robert Janes, president of the West Virginia auxiliary; and Mrs. J. Dennis Kugal, West Virginia president-elect.

Mrs. Loria addressed the group on the "Quality of Life" program which has served as the theme of her year. She stressed improving the quality of health education, strengthening the family unit, prolonging life, and definite concern for each other. She recommended the book by Dr. Lee Salk entitled "What Every Child Would Like His Parents To Know."

Mrs. Martha Hammer and Robert Evans entertained with a program of musical comedy favorites and contemporary music, accompanied by Mrs. Giner Pickering.

#### Today's Thought

"Is a miracle any less a miracle because it happens every day?"



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## Fifth District OSMA Councilor Dies

**David Fishman, M.D.**, Cleveland, member of The OSMA Council as Councilor of the Fifth District, died suddenly on May 22 after being stricken with a heart attack while attending a professional meeting in Cleveland.

Dr. Fishman was a practicing physician in Cleveland, specializing in internal medicine with emphasis on gastroenterology and was assistant clinical professor of medicine, Case Western Reserve University School of Medicine. He was a past president of the Academy of Medicine of Cleveland, had served on its Board of Directors, and had served a number of terms as delegate of the Academy to the OSMA House of Delegates, before being named to The Council.

He received his early education in the public schools of Cleveland, graduated from Adelbert College, Western Reserve University, earned a master's degree in physiology from Ohio State, and was awarded his M.D. degree by the OSU College of Medicine in 1937.

His internship was at St. Luke's Hospital, Cleveland, and was followed by residency training at Lakewood City Hospital. After a tour of active military service during World War II, he took additional residency training in gastroenterology at the Massachusetts General Hospital, Boston.

Among hospital appointments, Dr. Fishman had served as senior associate physician, St. Luke's Hospital, Division of Medicine; as head of the Department of Gastroenterology, St. Luke's, and as assistant physician in the Division of Medicine, University Hospitals, Cleveland.

Since becoming a member of The Council, Dr. Fishman served on a number of task forces and Association committees. He was chairman of the Advisory Committee to the Woman's Auxiliary, one of the OSMA members of the Committee for Voluntary Health Planning, and a member of The Council Fee Review Committee. In 1972 he was named by the OSMA House of Delegates as an Alternate Delegate to the AMA.

In other professional activities, he was a member of the American Medical Association, a founding member of the U. S. Committee of the World Health Organization, Fellow of the American College of Gastroenterology and Ohio governor for that college, Life Member of the American College of Physicians, member of the American Society of Internal Medicine, the Ohio and Cleveland Societies of Internal Medicine, the Western Reserve Medical Directors Association.

Among community activities and honors, he was director of medical relations for the Blue Cross of Northeast Ohio; president of the Cleveland Neighborhood Health Centers, Office of Economic Opportunity (Hough-Norwood); former president of Shaker Heights Association for Retarded Children; former trustee of the Cleve-



Dr. David Fishman, shown as he addressed the OSMA House of Delegates at the recent Annual Meeting in Columbus.

land Health Museum; member of the Executive Board and officer of the Comprehensive Health Planning Corporation; member of the Board and vice-president of the Northeast Ohio Regional Medical Program; member of the Board of Trustees, Cleveland Medical Library; chairman, Finance Committee of Metropolitan Health Planning Corporation; and member of the Research Committee of Physicians of Research and Planning Department, Blue Cross of Northeast Ohio.

Dr. Fishman has made a number of contributions to the medical literature and has collaborated on articles in his specialty field for the *American Journal of Physiology*, the *Journal of the American Medical Association*, *Annals of Internal Medicine*, and the *American Journal of Gastroenterology*.

He is survived by his wife, the former Florence Rice, and by two sons.



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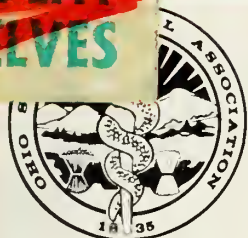
**Precautions:** In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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# *The Ohio State* MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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20 JUL 1973

Complete Reports on  
OSMA 1973 Annual Meeting  
Pages 524-574

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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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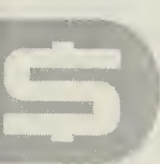
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# Ground-Breaking for OSMA Headquarters



Taking part in the Ground-breaking Ceremonies, from left, are: Dr. Ben Arnoff, Columbus Academy President, and the following members of the OSMA Building Committee: Dr. P. John Robeck, Immediate Past President; Dr. Maurice F. Lieber, Sixth District Councilor; Dr. David Fishman, Fifth District Councilor (since deceased); Dr. William R. Schultz, 1972-1973 President; Dr. Oscar W. Clarke, 1973-1974 President; Dr. James L. Henry, President-Elect and chairman of the committee; and Mr. Hart F. Page, OSMA Executive Director. To add the distaff touch, Mrs. Schultz mounted the power shovel, the machine that undoubtedly will finish what the hand shovels started.

Construction on the Ohio State Medical Association's Headquarters Building at 600 South High Street in Columbus is now underway following ground-breaking ceremonies there on May 9.

The construction site is on the corner of South High Street and Willow Street, on the southern fringe of the Columbus downtown area. More than 17,000 square feet of space will be provided on two floors and a basement. The exterior of the building is in keeping with the traditional architecture of the German Village, a large area south of the Columbus downtown area that has undergone considerable restoration in recent years.

Architect for the project is Kevin Flaherty and the contractor is the Tristar Construction Company, both of Columbus.

The decision to acquire the Association's own building was prompted by inflationary rental costs, especially in the downtown area, and the growing parking problem.

Parking space for 40 cars will be provided on the new property and arrangements have been made for additional parking space near the building to accommodate persons attending evening meetings. Occupancy of the new facilities is expected by the early months of 1974.



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**ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone.

**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism.

Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

**DOSE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

| INDICATION   | Average Daily Dosage<br>Tablets |
|--|---------------------------------|
| In the male:   |                                 |
| Eunuchoidism and eunuchism   | 10 to 40 mg.                    |
| Male climacteric symptoms and impotence due to androgen deficiency | 10 to 40 mg.                    |
| Postpubertal cryptorchidism  | 30 mg.                          |

**HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

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## OSU Graduates Record Medical College Class

(The following information was released to *The Journal* early in June, prior to the commencement exercises.)

A total of 344 students received medical degrees from Ohio State University's College of Medicine at spring quarter commencement Friday, June 8.

More doctors are graduating from Ohio State during 1973—a record 375—than from the other three Ohio medical schools combined, says Dr. Richard L. Meiling, Vice-President for Medical Affairs. Case Western Reserve University, the University of Cincinnati, and the Medical College of Ohio at Toledo have an estimated 214 graduates for the year, he said.

The largest June graduating class to receive medical degrees from the university is actually two classes: one, numbering 174, is the first class to complete a revised three-year curriculum, and the second, with 170 students, is the last class enrolled in the previous four-year curriculum.

Medical graduates will also receive degrees at summer and winter quarter commencements. Students may complete their course of study in 36 months or choose to take longer, possibly studying more elective subjects, he said. Consequently, students may decide to receive their degrees any quarter after they fulfill the requirements.

Hospitals are now willing to accept interns any time of the year, not just in July, which has been the traditional policy, so students are not limited to a June commencement.

A revised curriculum involving improvements and elimination of much vacation time means an extra year of professional life for the physicians, he said.

This is part of an effort to increase the number of physicians. The college has been increasing enrollment of its entering classes and now expects it to remain at 227 for several years with current facilities and the number of faculty members.

The larger classes in medicine, as well as larger classes in the School of Nursing and the

establishment of the School of Allied Professions, are the result of university commitments to the state in 1960 to increase the number of medical professionals. State and federal funding has provided for new and expanded facilities and additional faculty members needed for teaching the increased number of students.

## 'Family Physician' Scholarship Established in Toledo Area

The Toledo Chapter of the American Academy of Family Physicians (AAFP) has selected Donald Baker, a first year student at the Medical College of Ohio at Toledo to be recipient of the chapter's first scholarship award.

Baker, a graduate of Scott High School, holds degrees from the University of Toledo and Bowling Green State University. He served as assistant football coach at T.U. in 1969 and as youth coordinator for the Toledo Office of Economic Opportunity before applying for entrance to the Medical College.

Dr. John L. Culberson, vice-president of the chapter and chairman of the scholarship committee, said the \$400 award to Baker marks the first effort by Academy members in this area to provide financial aid to a student whose medical interests are directed toward family practice.

The local AAFP chapter proposes to furnish additional \$400 awards for each of Baker's three years at MCO. Also in each successive year, another student will be selected for the three-year scholarship, Dr. Culberson said, with the provision that the recipients maintain good grades and standing in their respective class.

The first award was presented at a dinner meeting in the Ramada Inn, Perrysburg.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during May. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

**CUYAHOGA (Cleveland)**

Richard B. Altemus  
Lynn W. Banowsky  
Allan B. Kunkel  
Andrew P. Saunders  
Kenneth M. Schreck  
Marta C. Steinberg  
Frits Van der Kuyp

**FRANKLIN (Columbus, except as noted)**

Narciso S. Albarracin  
Joseph D. Bullock  
Worthington  
John E. Hohmann  
Pataskala  
Charles E. Jordan  
Marvin Kaplan  
Chul Woo Lee  
Alan L. Longert  
William D. Padamadan  
Hilliard  
Padet Wattanasarn  
Henry A. Wise II

**GUERNSEY**

Kenneth L. Brooks  
Cambridge

**HAMILTON**

William R. Elsea  
Cincinnati  
Ghahreman Khodadad  
Cincinnati

**LAKE**

Sayed Mahmoud Hussny  
Mentor

**LORAIN**

Wilfredo Cruz  
Lorain

**LUCAS (Toledo)**

Sidney O. Fernandes  
Lily N. Sim  
Jon E. Starr  
Belkis Yuce

**MAHONING**

Vinod K. Sethi  
Youngstown

**MIAMI**

Bruce Mark Hess  
Troy

**MONTGOMERY (Dayton)**

Jeffrey D. Cao  
Donna L. Mitchell  
Raj K. Sharma

**SCIOTO**

Hector V. Soto  
Portsmouth

**STARK**

Louisa G. Fabella  
Canton  
Sudheer R. Shirali  
Canton

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## Thirty Receive M.D. Degrees at Toledo College Honorary Degrees Conferred

The Medical College of Ohio at Toledo conducted its second graduation ceremony on June 14 when 30 graduates received degrees as Doctors of Medicine. An additional graduate received his degree on last December 27.

In addition to the new graduates, the Medical College awarded honorary degrees to Dr. Robert A. Good and Dr. Irvine H. Page.

Dr. Good is the new president of the Sloan-Kettering Institute for Cancer Research, and director of research at the Memorial Sloan-Kettering Cancer Center.

A native of Minnesota, Dr. Good received his M.D. and Ph.D. degrees from the University of Minnesota in 1947. He is a pediatrician and anatomist and has also held academic posts in microbiology and pathology. In 1970, he received the coveted Albert Lasker Award.

Dr. Irvine H. Page received his M.D. degree from Cornell University in 1926 and subsequently played a distinguished role as an investigator and clinician in advancing medical understanding of hypertension, cardiovascular disease and stroke.

Among his many honors, Dr. Page has received the Lasker Award, the Distinguished Service

Award from the American Medical Association, and the Gold Heart (1962) and Heart of the Year (1969) Awards from the American Heart Association. In 1971 the American College of Cardiology presented him their Gifted Teacher Award.

Since 1945 he has served with the Cleveland Clinic Foundation and became consultant emeritus of the Foundation's research division in 1968. His books include major works on renal hypertension and arteriosclerosis.

Dr. Page is past president of the American Heart Association, a Fellow of the American Academy of Arts and Sciences and a Life Member of the American College of Physicians.

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Environmental health experts from throughout the world will attend an International Conference on Environmental Health next fall in Yugoslavia, the American Medical Association, one of the cooperating groups, announced. The conference will be held October 23-26, 1973, in Primosten, a resort area near the city of Split on the Adriatic Coast.

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## University of Cincinnati Junior Heads Student AMA

A junior at the University of Cincinnati College of Medicine, Russell W. H. Kridel, has been elected president of the Student American Medical Association for a year ending May, 1974.

Kridel, 24, of Englewood, N.J., is taking a year's leave of absence from the medical college to serve as official representative and spokesman for the national organization. His duties include extensive travel, during which Mr. Kridel hopes to visit all of the nation's 103 medical colleges. SAMA has 18,000 members from 91 of the colleges.

SAMA is independent of the American Medical Association, but maintains relations with it. Mr. Kridel is alternate delegate from the student section to the AMA, the primary delegate being the immediate past president of SAMA, George Blatti.

In 1971-72 Mr. Kridel was president of the UC chapter of SAMA. He has been active in state and national SAMA projects such as MECO (Medical Education and Community Orientation). As Ohio MECO state project director and a member of the National MECO Planning Committee he helped organize and administer the program which enables medical students to rotate through hospitals and clinics during their pre-clinical years.

Mr. Kridel was student initiator of and member of the Faculty Planning Committee for the

UC's College of Medicine "Interdisciplinary Program in Human Sexuality," a 40-hour program held in January, 1973. He has participated in the college's Family Care Program and two summers ago held a UC fellowship in otolaryngology and maxillofacial surgery.

A 1970 graduate of Stanford University, where he received a bachelor's degree in political science, Mr. Kridel served as president of the Stanford Pre-Medical Society in 1969-70. In 1968 for two quarters, Mr. Kridel participated in the Stanford-In-Italy campus in Florence.

Mr. Kridel is the son of Dr. and Mrs. Leonard Brown of Englewood, N.J. Dr. Brown is a specialist in obstetrics and gynecology.

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The Maternal and Child Health Program of the University of California School of Public Health, Berkeley, Calif. 94720 has announced its postgraduate programs for physicians. These programs lead to the degree of Master of Public Health. The announcement stated that applications are being accepted for September 1974.



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# Olympic Tragedy Sparks Sports Medicine Fund



Thomas M. Hughes, M.D., left, chairman of the "Class of 1942 David Berger Memorial Fund" project, presents initial check for the fund to Robert Atwell, M.D., third from left, representing the Ohio State University College of Medicine. Others from left to right are Benjamin Berger, M.D., of Cleveland, father of the late David Berger for whom the fund is named; Morris W. Keller, M.D., Cleveland, second from right, and William R. Beery, M.D., Canal Winchester, right.

A promising stimulus to sports medicine at Ohio State University College of Medicine has been launched with the establishment of the "Class of 1942 David Berger Memorial Fund," a program that will be used to sponsor visiting lecturers in sports medicine as well as other educational projects involving sports medicine.

David Berger, of Cleveland, was among the Israeli Olympic athletes killed by Arab terrorists during the Munich games in 1972.

The project was conceived during the 30th reunion of the OSU College of Medicine Class of 1942, was spearheaded by Thomas M. Hughes, M.D., of Columbus, and enthusiastically endorsed by Benjamin Berger, M.D., of Cleveland, father of David and a member of the class. Also active in planning were Morris W. Keller, M.D., of Cleveland, William R. Beery, M.D., of Canal Winchester, and Sol Maggied, M.D., West Jefferson,

all members of the class.

Dr. Hughes reported that class members initially contributed approximately \$1,300 to the project. Dr. Berger supplemented this amount with a donation of \$1,000. Members of the class have decided to contribute on an annual basis.

It is anticipated that the project will stimulate physicians-to-be to consider the practice of sports medicine in their career plans.

Dr. Maggied, chairman of the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association, said that the Committee would be honored to assist, if requested, in the selection of speakers and projects to be sponsored by the fund.

Persons interested in making contributions to the fund, or in obtaining additional information, are invited to contact Thomas M. Hughes, M.D., 481 E. Town Street, Columbus 43215.

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**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

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**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1. Gertler, M. M., et al.: Geriatrics 25:134-148 (May) 1970.



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Fertility and Sterility, January 1970  
Official Journal of the  
American Fertility Society

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**Warnings:** Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

**Precautions:** If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

**Adverse Reactions:** Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema. Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

**References:** 1. Montezano, P., and Evangelista, I. Methyltestosterone thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tittel, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zureick, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypochlosteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Callon, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:653, 1958. 6. Osel, A., and Farrar, G. E. United States Dispensary (ed 25). Lippincott, Philadelphia 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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# OAFP 23rd Annual Scientific Assembly

Ohio Academy of Family Physicians Will Present Program  
in Columbus Aug. 3-5, With Delegates First Meeting Aug. 2

**T**HE 23rd Annual Scientific Assembly of the Ohio Academy of Family Physicians will be held in Columbus, August 3-5. Headquarters will be the Sheraton-Columbus Motor Hotel in the downtown area.

The meeting will be open to all physicians, including interns and residents, and may be attended by medical students. For additional information, contact the OAFP at 4075 North High Street, Columbus 43214.

On Thursday, August 2, the Academy Golf Tournament will be held on the University Golf Course. A \$20 fee includes greens fee, lunch, and cost of prizes.

On Thursday afternoon the House of Delegates will meet. Final session will be on Friday morning.

Following are program features:

## Friday Afternoon, August 3

**Suicide, Murder or Natural Causes** — Lester Adelson, M.D., Cleveland, and Frank P. Cleveland, M.D., Cincinnati.

**Legal Liability in Treatment of Minors** — Stanley Laughlin, LL.B., Columbus.

**Battered Child Syndrome** — Bertram G. Girdany, M.D., Columbus.

Friday evening: Annual banquet.

## Saturday Morning, August 4

Each of the following clinical sessions will be held twice so that a physician may attend two full sessions, one beginning at 7:30 a.m., and the other at 8:15 a.m.

1. **Laparoscopy, Routine and Emergency Use** — Keith DeVoe, Jr., M.D., Columbus.

2. **Cardiology in the Elderly** — Robert C. Kirk, M.D., Columbus.

3. **Upper GI Endoscopy** — Donald E. Hoffman, M.D., Columbus.

4. **Gynecology in the Elderly** — L. David Hall, M.D., Columbus.

5. **Management of Status Asthmaticus** — James I. Tennenbaum, M.D., Columbus.

6. **Aggressive Management of Cardiac Arrhythmias** — Alan E. Sheline, M.D., Columbus.

7. **Psychiatry in Family Practice** — Frank J. Ayd, Jr., M.D., Baltimore.

8. **Orthopedic Injection Techniques and Management of Simple Fractures** — Walter H. Hauser, M.D., Columbus.

9. **Obesity — Rational Treatment** — Thomas G. Skillman, M.D., Columbus.

10. **Breast Cancer** — John Minton, M.D., Columbus.

11. (7:30-9:00) **Expanding Your Time Through the Proper Use of Medical Assistants** — Robert R. Johnson, M.D., Columbus.

(General Session) **Acid Base Balance and Blood Gases as Related to Chronic Obstructive Lung Disease** — Roy L. Donnerberg, M.D., Columbus.

**Chronic Obstructive Lung Disease Treatment** — Robert G. Loudon, M.B., Ch.B., Cincinnati.

## Saturday Afternoon

**Dermatologic Manifestations of Systemic Disease** — Edmund D. Lowney, M.D., Columbus.

**Problems with Problem Oriented Records** — William A. Stowe, M.D., Dayton, and Paul Y. Ertel, M.D., Columbus.

**Cryosurgery and Hyfrecaction (Dermatology)** — J. Michael Hazel, M.D., Springfield.

**Cryosurgery (Ob-Gyn)** — Charles J. Burns, M.D., Lima.

**Scopes (Internal Medicine)** — Richard D. Ruppert, M.D., Columbus.

Ladies tour of the Ohio Historical Museum Complex begins at 1:30 p.m.

Evening: Marion Laboratories Party and Officers' Reception.

## Sunday Morning, August 5

7:30 and 8:15 a.m., repeat of the first ten of Saturday's Clinical Sessions.



*(Family Physicians—Contd.)*

General Session: **Headaches and Chronic Fatigue** — Frank J. Ayd, Jr., M.D.

**Osteomalasia and Osteoporosis** — Manuel Tzagournis, M.D., Columbus.

**Present Status of Acupuncture (P.S.S.)** — L. Y. Soo, M.D., Lima.

## OAFP Educational Programs for Year Announced

The Ohio Academy of Family Physicians, 4075 North High Street, Columbus, has announced the following educational programs which it is sponsoring or cosponsoring.

August 3-5 — **Annual Scientific Assembly**, Sheraton-Columbus Motor Hotel, Columbus.

November 8 — **Conference on Alcoholism/Drug Abuse** — Imperial House North, 900 Morse Road, Columbus.

November 10-11 — **Economics Workshop** — Scot's Inn Motel, 4900 Sinclair Road, Columbus (near I-71 and Morse Road).

November 11 — **Medical Assistants Refresher** — Scot's Inn Motel, Columbus.

January 5-6; and 19-20 — **Family Medicine Review** — Sheraton Motor Inn North, 888 E. Granville Road, Columbus.

February 8-10 — **Pediatric Workshop** — Hueston Woods Lodge, College Corner.

March 24 — **Lederle Symposium** — Sheraton-Columbus Motor Hotel.

March 23-24 — **Paramedical Workshop** — Ramada Inn North, Route 161 at I-71, Columbus.

April 19-21 — **Family Relations Workshop** — Sawmill Creek Lodge, Huron.

May 7-20, 1974 — **International Conference on Diagnostic Medicine** — Nice, France, and Rome, Italy.



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# Obituaries

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**Charles Robert Baker, M.D.,** Sturgis, Mich.; Ohio State University College of Medicine, 1936; aged 62; died about April 25; former member of OSMA; Fellow, American College of Surgeons; practitioner in Columbus for about 20 years before he moved to Michigan.

**Glenn E. Chamberlain, M.D.,** Twinsburg; Western Reserve University School of Medicine, 1932; aged 66; died May 7; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner in Twinsburg for 38 years, formerly in association with his father, the late Dr. Robert B. Chamberlain.

**Giles Anthony DeCourcy, M.D.,** Cincinnati; University of Cincinnati College of Medicine, 1911; aged 86; died May 12; member of OSMA and AMA; practitioner of long standing in Cincinnati, specializing in obstetrics and gynecology; Cincinnati fire surgeon for some 40 years. He was a member of a family of physicians, his grandfather, father, and four brothers were doctors. Dr. Cornelius DeCourcy, of Cincinnati, is a nephew.

**George Wendell Dunlap, M.D.,** Toledo; Rush Medical College, 1913; aged 88; died December 9; member of OSMA and AMA; practitioner of long standing in Toledo, specializing in obstetrics and gynecology.

**Leon Simpson Evans, M.D.,** Cleveland; Western Reserve University School of Medicine, 1921; aged 84; died May 25; former member of OSMA; member of the National Medical Association; practitioner of long standing in Cleveland.

**Joseph Albert Freiberg, M.D.,** Cincinnati; University of Cincinnati College of Medicine, 1923; aged 74; died May 1; member of OSMA and AMA; Fellow, American College of Surgeons; diplomate, American Board of Orthopaedic Sur-

gery, and member of several other professional organizations; professor emeritus, UC College of Medicine; practitioner of long standing in Cincinnati; past president, American Academy of Orthopaedic Surgeons; past vice-president, Clinical Orthopaedic Society; former associate editor of the *Journal of Bone and Joint Surgery*; Among survivors is his son, Dr. Richard Freiberg, of Cincinnati.

**Jack Rene Henry, M.D.,** Cleveland; Ohio State University College of Medicine, 1943; aged 54; died April 4; member of OSMA and AMA; practitioner for many years in Cleveland, specializing in orthopaedics and general surgery; veteran of World War II.

**Benjamin Harrison Hildreth, M.D.,** Akron; University of Louisville School of Medicine, 1916; aged 84; died May 17; member of OSMA and AMA; general practitioner and general surgeon for more than 50 years in Akron; veteran of World War I.

**Oliver John Kechele, M.D.,** Berea; Western Reserve University School of Medicine, 1927; aged 72; died May 3; member of OSMA, AMA, and American Academy of Family Physicians; practitioner of long standing in Berea; veteran of World War II.

**John K. Larkin, M.D.,** Dayton; State University of N.Y. Downstate Medical Center, 1908; aged 91; died April 25; member of OSMA and AMA; practitioner for some 65 years in Dayton; veteran of World War I.

**Elmer Carl Unckrich, M.D.,** Toledo; University of Michigan Medical School, 1904; aged 92; died May 21; member of OSMA and AMA; Fellow, American College of Surgeons; practitioner of long standing in Toledo before his retirement. His specialty was the EENT field.



## Placidyl® (ETHCHLORVYNOL) Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated for short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients against possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or performing hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulant might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY FOR A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who tend to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuance of the drug. Drug dosage should be limited in severely debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pains controlled with analgesics. Caution is advised in prescribing the drug for patients who are also being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients respond unpredictably to barbiturates or alcohol who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, syncope without marked hypotension. Transient dizziness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction manifested by urticaria have been reported following oral administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. In cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 307454



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VOLUME 69

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## Blood as a Medicine

MELANIE KENNEDY, M.D.

IN ANTIQUITY, blood was considered to be one of the four humors of the body. Since disease was felt to originate from an excess of one of these humors, doctors could rid the body of sweat, urine, or feces through the use of plasters, potions, cathartics, and purges. They invented bloodletting as the exit for the fourth humor. This was practiced until the middle of the 19th century, when it became obvious patients died more quickly and in greater numbers from bloodletting than from other treatments.<sup>1</sup>

Now, we treat many diseases not by bloodletting, but by blood transfusion. Transfusion therapy is a rather recent science, with rapid development during the past 30 years. We have found that blood is not a tonic or a magical potion, but it does contain many valuable components which can be used to treat anemia, coagulation disorders, shock, hypoproteinemia, and even to prevent certain infectious diseases. The advent of plastic blood collection equipment has made possible the safe and efficient separation of blood into its various components (Fig. 1). Component therapy puts blood transfusion on a scientific, rational basis, by

### *The Author*

• Dr. Kennedy, Columbus, is Medical Director, Central Ohio Red Cross Blood Program.

using specific components for specific problems, just as we use drugs.

### Whole Blood

The average amount of blood in one unit is 450 ml. This is diluted with 67.5 ml of acid-citrate-dextrose (ACD) solution or 63 ml of citrate-phosphate-dextrose (CPD) solution to give a resulting hematocrit of 35 to 40 percent and a total volume of 515 ml. As blood ages, the metabolism of the red cells results in increasing amounts of lactic acid and also higher levels of plasma potassium, ammonia, and hemoglobin. The plasma also contains various antigens and antibodies, many of them capable of causing febrile or allergic transfusion reactions.<sup>2,3</sup> It may also carry the vectors of hepatitis, and other infections, such as cytomegalovirus.

Many of the benefits of blood are lost with storage, such as short-lived platelets, and labile

The opinions and assertions expressed herein are those of the author and do not necessarily bear relationship to the policies or views of the American Red Cross.

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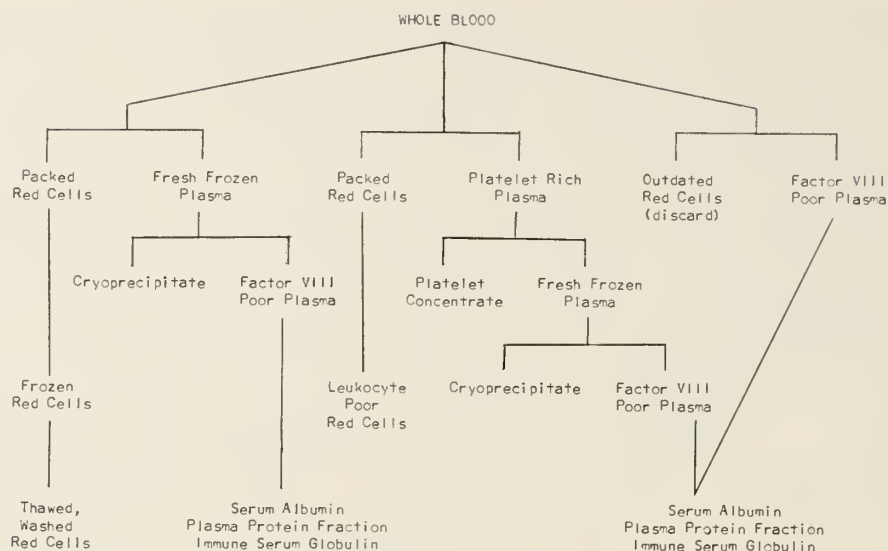


FIG. 1. Flow sheet of blood components.

factors V and VIII. Whole blood must be less than 24 hours old in order to deliver significant amounts of these to the recipient. It is much better to transfuse these factors as components (see below), since larger amounts of the needed factor(s) may be delivered in a small volume.

The primary function of red blood cells is to deliver oxygen to the tissues. Therefore, the indication for red cell transfusion is deficiency of circulating red cell mass. This cannot be determined by a specific number of grams of hemoglobin or level of hematocrit. For example, recent experience in major renal dialysis centers, including The Ohio State University, has shown that patients are able to function well with a hemoglobin level of 7 to 8 gm per 100 ml (personal communication, T. F. Ferris). Renal transplant teams are aware of the dangers of hepatitis and sensitization to foreign antigens, which may endanger the survival of the homograft, and thus they are reluctant to transfuse patients without compelling reasons.

Additionally, major surgery involving Jehovah's Witnesses has shown that low hemoglobin levels can be tolerated remarkably well.<sup>4</sup> These hemodilution technics have been extended to other patients, including those having cardiac by-pass procedures.<sup>5</sup> The hemodilution appears to protect the blood from pump damage to a degree and it improves the perfusion of the microcirculation.

With hypoxia from whatever cause, a product of anaerobic glycolysis, 2,3-diphosphoglycerate (2,3-DPG), is formed and binds to the hemoglobin molecule, increasing the oxygen release to the tissues.<sup>6</sup> The body has other mechanisms of compensating for anemia (Table 1). The effectiveness

of these is evident in that moderate anemia has few associated symptoms.<sup>7</sup> Many blood transfusions are used now to treat hypovolemia and shock, which are more appropriately treated with plasma expanders and balanced salt solutions. "Red stuff" just carries oxygen; it does not plug up leaky capillaries or aid in coagulation to stop bleeding.

### Components and Derivatives

Many of the constituents of blood are more valuable as therapeutic agents when separated from the rest of the unit. The main advantage of separation is that the needed component can be given in much greater quantity since the suspending volume is reduced. Also, one unit of blood can be used by several patients, instead of one, as in the case of whole blood (Fig. 1).

Plasma that has not been fractionated probably never should be administered except for its coagulation factors. Stored plasma has too many injurious metabolic products and has lost many of its valuable components as well as factors V and VIII.

*Red Cells.* The potassium and ammonia in a unit of whole blood are especially detrimental to patients with liver or kidney disease. Also, the plasma proteins can sensitize any patient,<sup>3,7</sup> not

TABLE 1. Compensatory Mechanisms in Anemia

|  |
|--|
| Increased 2,3-diphosphoglycerate (decreased O <sub>2</sub> affinity)                   |
| Increased plasma volume  |
| Increased cardiac output with exercise   |
| Decreased hemoglobin CO <sub>2</sub> buffering with decreased O <sub>2</sub> unloading |



just those awaiting organ transplant. The volume of plasma in whole blood can cause the cardiac patient to decompensate and develop pulmonary edema. All these things can be avoided by making a product called packed red cells, or more recently called, simply "red blood cells." By using a plastic bag with one or more integral satellite bags (Fig. 2), enough plasma and citrate can be removed to leave an approximate 70 percent suspension of red blood cells. The shelf life remains at 21 days, with the same in vivo viability as whole blood.

Who should receive red blood cells (packed) instead of whole blood? Anyone who is not bleeding rapidly.<sup>2,3</sup> This would include more than half of the patients who receive blood; some experts estimate 80 percent.

The best red cell preparation is frozen, thawed, washed red cells. Glycerol is added to the fresh red cells and the mixture is frozen at low temperature. The red cells can remain frozen for longer than ten years.<sup>8,9</sup> After thawing, the red cells are washed and resuspended in dextrose-saline solution. The washing procedure removes all plasma constituents, almost all of the white cells, and apparently the hepatitis virus.<sup>10</sup> The red cells have the same oxygen-carrying capacity as before freezing, and have the same posttransfusion survival.<sup>8,11,12</sup> The disadvantages of this procedure are the cost of equipment and labor — about three to four times that of a unit of whole blood — and

the 24-hour outdate after thawing. However, the advantages probably outweigh the disadvantages: a hepatitis and leukocyte-poor red cell preparation for patients awaiting organ transplant; those having leukocyte antibodies; those having multiple antibodies (thus requiring rare blood); or for autologous transfusions.

**Leukocyte-Poor Cells.** With centrifugation, leukocytes form the buffy layer between the red cells and plasma. By separating the plasma and buffy coat from the red cells, the red cells are made "leukocyte-poor" and the plasma is made "leukocyte-rich." Leukocyte-poor red cells also can be made by several other methods, including filtration and washing.<sup>2,3</sup> Leukocyte-poor red cells are useful for those patients who have developed leukocyte antibodies, often as the result of many transfusions or multiple pregnancies.

Much work has been done in recent years on leukocyte as well as lymphocyte antibodies. The HL-A system of tissue typing has shown that lymphocytes and other body tissues share certain antigens which allow our bodies to differentiate between self and foreign tissue. The HL-A system is a very complicated one, and only one person in 1,000 matches another.<sup>13</sup> For this reason, whole blood transfusion (which includes lymphocytes) from random donors has a high risk of sensitizing a patient to one or more foreign HL-A antigens, thus causing an accelerated rejection of homo-

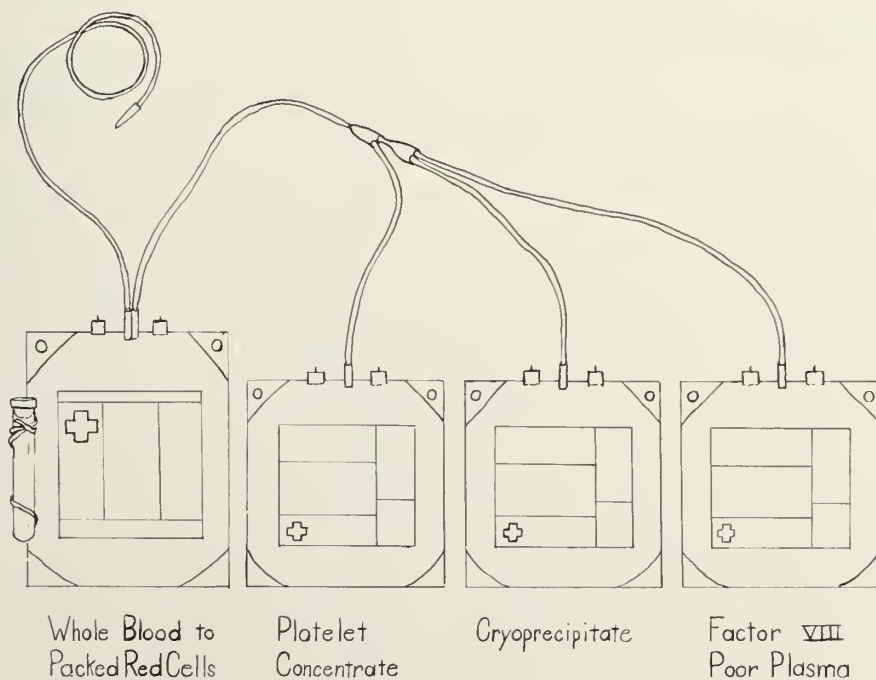


Fig. 2. Quadruple blood collection set. Primary bag is on left and is integrally attached to three satellite bags. Labels indicate possible blood products (see Fig. 1).

graft tissue, such as a kidney. This antigen-antibody reaction is called a "graft rejection."

**Platelets.** Platelets can be given in four ways: fresh whole blood, fresh packed red cells, platelet rich plasma, and platelet concentrates. Platelet-rich plasma and platelet concentrates are effective even when stored for 24 to 72 hours; whereas, platelets retain their viability in whole blood or red cells less than 24 hours.<sup>14</sup> Of course, if your patient needs only platelets, platelet concentrate is the component of choice.

Platelet transfusion is indicated when the platelet count drops below 20,000 per cu mm (some sources say 10,000 per cu mm),<sup>2</sup> or when platelet dysfunction is suspected and the patient is bleeding. These usually are patients undergoing immunosuppressive therapy, chemotherapy for neoplasia, or those receiving massive, rapid blood replacement.

Each unit of platelet concentrate will raise the adult patient's platelet count 5,000 to 10,000 per cu mm. The average platelet transfusion would thus be 8 to 10 units. The patient should be monitored by platelet counts after transfusion to check response. Generally, platelet transfusions can be spaced about two to four days apart, except in patients who have received several months of platelet therapy and have developed antibodies.

**Fresh Frozen Plasma (FFP).** If the plasma is separated from the red cells within four hours of collection, the plasma can be frozen and *all* the clotting factors (except platelets) preserved.<sup>2</sup> Fresh frozen plasma (FFP) is indicated in multiple clotting deficiencies such as those associated with liver disease and massive transfusions. The volume of FFP, 225 ml per unit, limits the amount that may be transfused.

**Cryoprecipitate (Factor VIII and Fibrinogen).** Frozen plasma, when slowly thawed at refrigerator temperature, forms a precipitate, which contains about 55 percent of the original amount of factor VIII, and about 25 percent of the fibrinogen.<sup>2</sup> The precipitate must then be refrozen at -30 C in order to preserve its potency. With a volume of less than 10 ml, many units of cryoprecipitate can be administered to a patient with classical hemophilia. Cryoprecipitate is of no value in other forms of hemophilia such as Christmas disease.

**Plasma Protein Fraction (PPF) (Plasmate,<sup>®</sup> Protinate,<sup>®</sup> and others).** This is a 5 percent solution of purified plasma protein, principally serum albumin, which has been heat treated to kill the hepatitis virus (Table 2). It is packaged in 250 ml vials. This product is the first choice in burns and as a volume expander during shock or surgery.<sup>2</sup>

**Serum Albumin.** This is available in 25 percent salt-poor solution in 50- or 100-ml vials. The

TABLE 2. Plasma Derivatives (Produced from Pooled Plasma)

|  |
|--|
| * Serum albumin                                |
| * Plasma protein fraction                      |
| * Immune serum globulin                        |
| Fibrinogen                                     |
| Factors II, VII, IX, and X complex concentrate |
| AHF (factor VIII) concentrate                  |

\* No hepatitis transmission

solution is heat treated which inactivates the hepatitis virus (Table 2). Albumin is useful in treating patients with hypoproteinemia associated with fluid retention and high body sodium. Albumin should be used cautiously because of its hyperosmolality and ability to draw water into the circulation,<sup>2</sup> and should not be given alone to patients with dehydration.

**Immune Serum Globulin (ISG).** This preparation is mostly gamma globulin (IgG), but also contains traces of IgM, IgA, albumin and other proteins. This product has never been reported to transmit hepatitis.<sup>2</sup> ISG is used in prophylactic treatment of a-, hypo-, and dys-gammaglobulinemia. It also can be used in modification of infectious hepatitis, poliomyelitis, and possibly herpes simplex. The following hyperimmune serum globulins also are available (see Table 3 for source of supply): pertussis, tetanus, vaccinia, mumps, measles (rubeola), and anti-Rh(D) (RhoGAM<sup>®</sup>). Research is now being conducted on herpes zoster, rabies, and serum hepatitis immune globulins. Immune globulins should be used only when indicated, since the injection of any protein carries some risk.

**Fibrinogen.** This is a dried, purified product which must be reconstituted just before administration. One vial contains at least two grams.<sup>2</sup> Fibrinogen has a very high rate (30 to 40 percent) of hepatitis transmission, as it is made from pooled plasma and cannot be pasteurized. For this reason, cryoprecipitate is usually preferred. Personnel handling fibrinogen should be cautioned that the vial may contain infectious material.

Fibrinogen can be used in the treatment of congenital hypo- or a-fibrinogenemia (very rare conditions). Although fibrinogen also has been used for acquired hypofibrinogenemia, as in obstetrical cases, it appears heparin is the preferred therapy.<sup>15</sup> Acquired hypofibrinogenemia is almost always due to intravascular coagulation using up plasma fibrinogen ("consumption coagulopathy"). Adding fibrinogen by transfusion just propagates the clots, and embolism can complicate the patient's state. Heparin, by helping dissolve the clots and reversing clot propagation, thus becomes the drug of choice.<sup>7</sup>

**AHF Concentrate (Factor VIII).** Lyophilized (dried) concentrates can be manufactured from

fresh frozen plasma. The high potency product contains more than 600 units of antihemophilic globulin (AHF) or the equivalent of five to six cryoprecipitates.<sup>2</sup> AHF concentrate has simplified the home treatment programs of many hemophiliacs, since it is easy to store. Like fibrinogen, AHF concentrate has a high rate of hepatitis, for the same reasons. It should be used only for classical hemophilia.

*Factors II, VII, IX, X Concentrate (Konyne®).* This is another dry product which must be reconstituted. Hemophilia B (factor IX deficiency) can be treated effectively with this product.<sup>16</sup> This concentrate, like all those made from pooled plasma and not heat treated, has a high rate of hepatitis. For this reason, fresh frozen plasma is preferred in diseases other than clinical hemophilia, if volume is not a problem.

*A Word About Hepatitis.* All Red Cross Blood Centers and most other blood centers are now testing for hepatitis B antigen (HAA). Blood that is positive for HB Ag is not used for transfusion in any form. However, the tests presently in use are inadequate and miss some hepatitis carriers. In systems using entirely volunteer donors, only a few donors are missed. This is a reasonable risk when transfusing single units of whole blood or components. However, the risk becomes very great when plasma is pooled and processed into products which cannot be pasteurized, such as fibrinogen, AHF concentrate, and prothrombin complex con-

centrate. The risk of the latter two was not fully realized until after considerable clinical trial. Many hemophiliacs did not develop hepatitis, probably because of acquired immunity from previous exposure to hepatitis-infected plasma. Unpasteurized products, which have a high rate of infectivity, pose unaccepted risks for patients in liver failure, undergoing heart surgery, or suffering from trauma. It is better to use "single donor" products, such as fresh frozen plasma and cryoprecipitate.

The cost of these products varies greatly from area to area with the percentage of paid vs volunteer personnel as well as donors. As a rule, commercial products are much higher in cost than those produced by the Red Cross and Community Blood Banks.

If you would like more detailed information, the publications, *General Principles of Blood Transfusion*<sup>7</sup> and *Blood Component Therapy*<sup>2</sup> are particularly recommended. Both are quite inexpensive. And if you have a particular problem with which you would like some help, see your local, friendly Blood Banker!

**Acknowledgment:** My appreciation to Dr. Robert Westphal, University of Vermont, and Dr. Tibor J. Greenwalt, American National Red Cross, who kindly reviewed this manuscript.

**Generic and Trade Names of Drugs**  
Plasma protein fraction — Plasmanate (Cutter Laboratories); Protenate (Hyland Laboratories)  
Factors II, VII, IX, and X — Konyne (Cutter Lab-

TABLE 3. Sources of Supply for Blood Products

| Product   | Source of Supply   | Storage Temperature | Outdate     |
|---|--|---------------------|-------------|
| Whole blood   | American Red Cross (ARC),<br>Community Blood Banks (CBB) | 4 C                 | 21 days     |
| Packed red cells  | ARC, CBB   | 4 C                 | 21 days     |
| Leukocyte-poor red cells  | ARC, CBB   | 4 C                 | 21 days     |
| Frozen, washed red cells  | ARC*, CBB†   | 4 C                 | 24 hours    |
| Platelet rich plasma  | ARC, CBB   | 4 C to -25 C        | 24-72 hours |
| Platelet concentrate  | ARC, CBB   | 4 C to -25 C        | 24-72 hours |
| Fresh frozen plasma   | ARC, CBB   | -30 C               | 1 year‡     |
| Cryoprecipitate   | ARC, CBB   | -30 C               | 1 year‡     |
| Serum albumin   | ARC, commercial firms                                    | 4 C                 | 3 years     |
| Plasma protein fraction   | ARC, commercial firms                                    | 4 C                 | 5 years     |
| Fibrinogen  | Commercial firms   | 4 C                 | 5 years     |
| Prothombin complex concentrate  | Commercial firms   | 4 C                 | 1 year      |
| AHF concentrate   | ARC, commercial firms                                    | 4 C                 | 1 year      |
| Immune serum globulin   | ARC, commercial firms                                    | 4 C                 | 3 years     |
| Hyperimmune globulins: pertussis,<br>tetanus, mumps, measles, RhoGam® | Commercial firms only                                    | 4 C                 | 3 years     |
| Hyperimmune globulins: vaccinia,<br>rabies, herpes zoster             | Communicable Disease Center only§                        | 4 C                 | unknown     |

\* Columbus and Cleveland only  
† Cincinnati only  
‡ six months -20 C  
§ Red Cross can give information



oratories)  
Rho(D) immune globulin — RhoGAM (Ortho Diagnostics)

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## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

This 65-year-old white man enters your office wondering if anything can be done regarding his gradually enlarging nose (Fig. 1). This problem began 30 years ago when he first noted red blemishes and pustules occurring on his nose.

What is the diagnosis and method of treatment?

(See p. 523 of this issue for further information and discussion.)

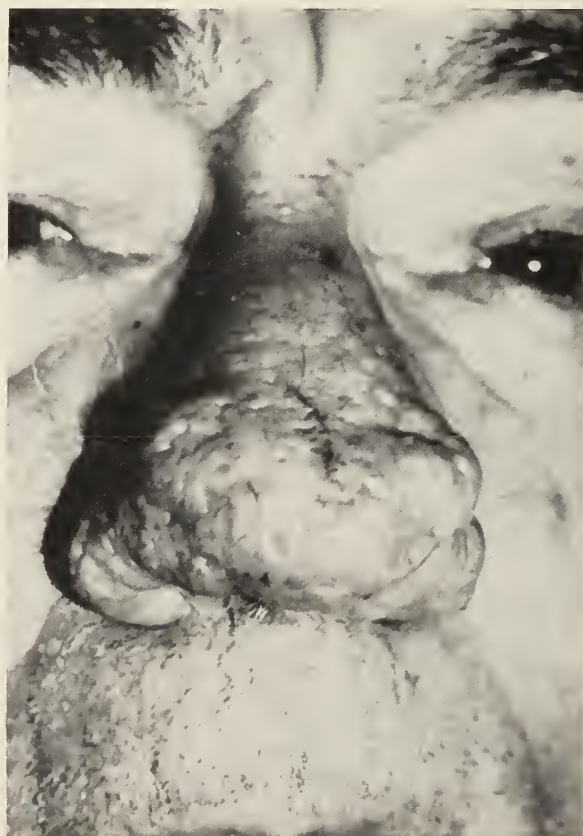


FIG. 1. This man has noted a gradual enlargement of his nasal tip.

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Submitted February 22, 1973.

# The Role of Microsurgery in Treatment of Occlusive Cerebrovascular Disease

GHahreman Khodadad, M.D., AND ROBERT L. McLaurin, M.D.

UNTIL ABOUT A DECADE AGO, it was not possible to repair small vessels and keep them constantly patent. Gross suture technics, adhesives, and various prostheses were used without much success.<sup>1</sup> In 1960, Jacobson and Suarez<sup>2</sup> pioneered the technic of microsuture and produced a patency rate of 100 percent. This was a breakthrough in the surgery of small vessels. Similar results of repair and replacement of 1- to 2-mm arteries were reported by Khodadad and Loughheed<sup>3</sup> at the American Academy of Neurological Surgery in 1964. Following the development of basic principles of microvascular repair, some surgeons<sup>4-6</sup> began to use this method in embolectomies and endarterectomies of cerebral arteries and, at the same time, search was continued for the development of new surgical approaches to occlusive cerebrovascular disease.<sup>7-9</sup>

Although a majority of stroke patients with transient ischemic attacks (TIAs) or small strokes suffer from the atherosclerotic occlusive disease, the site of their lesions varies significantly. The purpose of this paper is to categorize these patients from the surgical point of view and to discuss the role of microsurgery in their treatment.

1. *Occlusive disease of the common carotid and vertebral arteries at their origin.* Only a small proportion of the patients fall in this category. Surgical treatment for this group of patients consists of endarterectomy or by-pass procedures in the innominate or subclavian arteries through a trans-thoracic approach or endarterectomy in the vertebral arteries by a transcervical route.

2. *Unilateral or bilateral cervical internal carotid artery stenosis.* Most of the patients with TIAs or small strokes fall in this group and are treated by carotid endarterectomy. In bilateral carotid stenosis, however, it is important to know

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which artery should be operated upon first. The factors that should be seriously considered in this selection are: the type of circle of Willis, the severity of stenosis, and the relationship of the lesion to the dominant hemisphere. The first operation is usually done on the artery which contributes less blood to the brain, and if both arteries have similar anatomic distribution and the same degree of stenosis, the artery on the nondominant hemisphere is operated upon first.

3. *Unilateral cervical internal carotid artery stenosis and contralateral carotid artery occlusions.* This is the second largest group of patients with TIAs and small strokes. Endarterectomy of the stenotic carotid in this group of patients is sometimes complicated by stroke, and for this reason, surgery is not recommended in these patients in some institutions.<sup>10</sup> The risk is related to the anatomy of circle of Willis, the degree of intracranial vascular disease, and whether or not associated disease of the vertebrobasilar system is present.

When there is bilateral hypoplasia of the posterior communicating arteries (the incidence is 6 percent),<sup>11</sup> temporary occlusion of the stenotic carotid practically stops the blood flow to the

anterior two thirds of both hemispheres (Fig. 1A). If the posterior cerebral artery on the side of the stenotic carotid arises from the internal carotid (15 percent)<sup>11</sup> as shown in Figure 1B, temporary occlusion of this vessel would result in even greater jeopardy to the cerebral circulation. The presence of ipsilateral or bilateral middle or anterior cerebral artery disease (Fig. 1C) may also contribute to the neurologic complication. Another possible cause of complication is severe disease of the vertebrobasilar system (Fig. 1D). Under these circumstances, especially when signs of cerebral ischemia are noted in the electroencephalogram following the temporary compression of the stenotic carotid artery, a different surgical approach may be chosen. This consists of a by-pass vein graft from the common carotid to the supraclinoid carotid artery on the side of completely occluded carotid,<sup>12,13</sup> as shown in Figure 1E. When the cerebral circulation is strengthened by such procedure, endarterectomy on the stenotic carotid may be performed more safely.

4. *Unilateral or bilateral cavernous carotid disease.* It is not uncommon to see patients with TIAs or mild strokes who suffer from severe stenosis of the cavernous portion of the carotid artery. Sometimes such stenosis is associated with complete occlusion of the contralateral internal carotid with or without occlusive disease of the vertebrobasilar system. Since the cavernous carotid is not accessible, a by-pass vein graft from the common carotid to the supraclinoid carotid or an anastomosis between the superficial temporal ar-

tery and a temporal branch of the middle cerebral artery may be of value.

As in other surgical procedures for stroke, the management is based on two objectives: the relief of existing symptoms and prevention of future disability or death from stroke. In general, the same surgical indications and contraindications that are used in occlusive disease of the cervical internal carotid are applied to the cavernous carotid. However, since we are dealing with more distal arteries, particular attention should be paid to the anatomy of circle of Willis, multiplicity of occlusive arterial disease, newly formed collateral channels, and the dominant cerebral hemisphere.

When unilateral cavernous carotid stenosis is present and the supraclinoid carotid artery appears normal, the procedure of choice is cervical internal carotid-supraclinoid carotid by-pass graft followed by ligation of the internal carotid artery in the neck distal to the graft (Fig. 2A). If the supraclinoid carotid or the middle cerebral artery is involved with atherosclerosis, anastomosis of the superficial temporal artery to the anterior temporal branch of the middle cerebral artery followed by long-term anticoagulant therapy is a safer procedure (Fig. 2B).

In bilateral cavernous carotid stenosis, a by-pass graft may be established on the side which contributes less blood to the cerebral circulation. If the patient has suffered from TIAs due to platelet embolization and the operated side is responsible for the attacks, the internal carotid is ligated on that side. If the operation is done on the

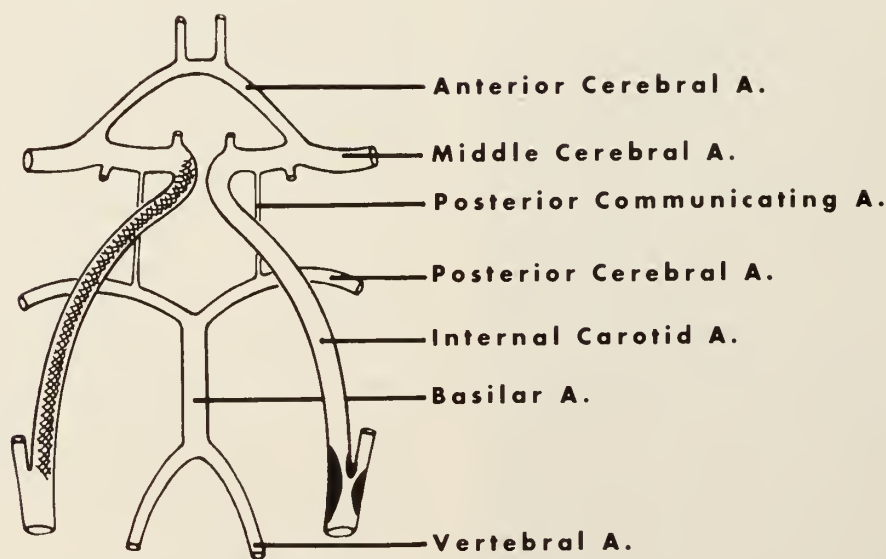


FIG. 1A. Complete occlusion of one carotid and stenosis of other carotid artery with bilateral hypoplasia of posterior communicating artery.



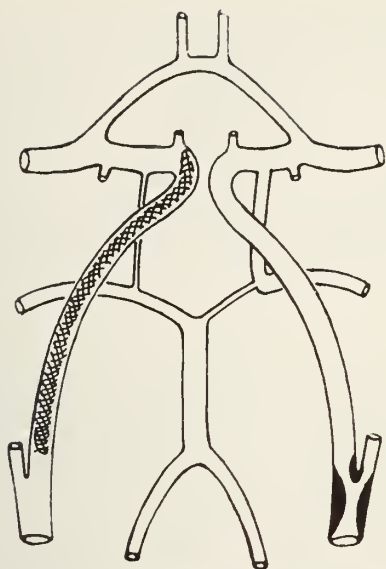


FIG. 1B. With large posterior communicating artery ipsilateral to stenotic carotid.

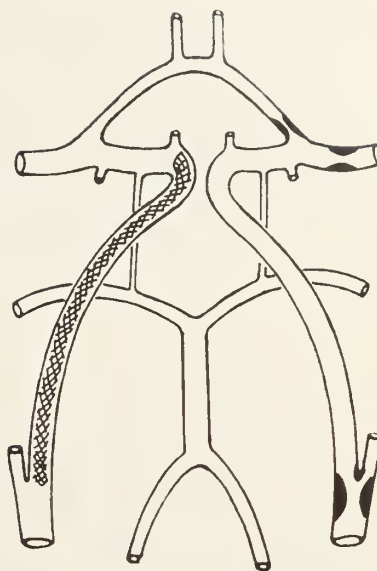


FIG. 1C. With occlusive disease of ipsilateral middle and anterior cerebral arteries.

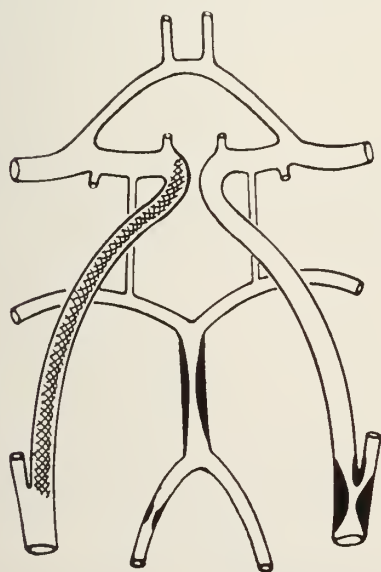


FIG. 1D. With significant occlusive disease of the vertebrobasilar system.

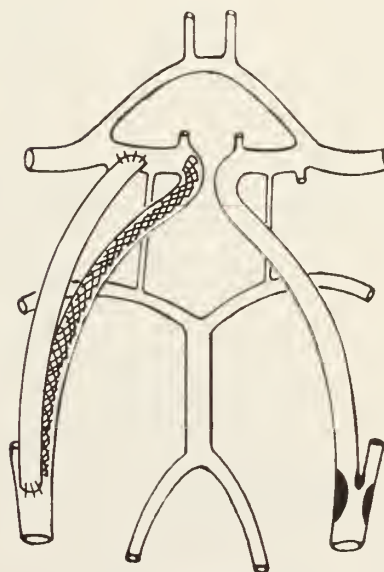


FIG. 1E. A common carotid-supraclinoid carotid by-pass graft.

asymptomatic side, anticoagulant therapy is initiated to prevent further embolization.

When unilateral cavernous carotid stenosis is associated with complete occlusion of the contralateral internal carotid, a by-pass graft on the side of the completely occluded carotid with or without anticoagulant therapy may be indicated (Fig. 2C).

5. *Occlusive disease of the proximal intracranial arteries.* The cause of occlusion in the

majority of patients is atherosclerosis. Occasionally a large embolus blocks a major intracranial artery,<sup>5,14</sup> and in rare occasions, the stenosis or occlusion is due to intimal hyperplasia or fibromuscular hypertrophy.<sup>15,16</sup> Embolectomy in an alert patient with an embolus of only a few hours duration seems to be warranted. The arterial wall in these cases is usually free of atherosclerosis and surgical repair is relatively easy under magnification. When the cause of occlusion is atherosclerosis or a non-

specific vascular disease, the results of arterial repair may not be encouraging because of the primary arterial disease in a small caliber vessel. In such circumstances, a superficial temporal-artery anastomosis or an occipital-artery anastomosis or an occipital-artery anastomosis seems to be the procedure of choice.

6. *Occlusive disease of the distal intracranial arteries.* At the present time, there is no surgical

procedure that could be considered in this group of patients. Preliminary results of the experimental implantation of the superficial temporal artery into the brain<sup>17</sup> have shown that communications between the implanted artery and the brain arteries may develop within months or possibly earlier. Whether or not such a procedure can be used eventually in patients with small cerebral artery disease depends on the results of further laboratory studies in this field.

## Discussion

It should be pointed out that although the technics of extracranial-intracranial by-pass grafts and anastomoses are developed, there is very little known about the selection of the patients and the results of these operations. At the present time, microvascular procedures for stroke are at the stage that cervical carotid endarterectomy was about 15 years ago. They may readily fall into a similar developmental path as that of the cervical carotid artery surgery, and within 10 to 15 years, they may be considered well settled and almost routine surgical procedures in the management of a selected group of stroke patients. Until then, however, extreme caution must be exercised in selecting patients and the surgical approach.

## Summary

From the surgical point of view, patients with transient ischemic attacks or small strokes are divided into six groups on the basis of anatomical

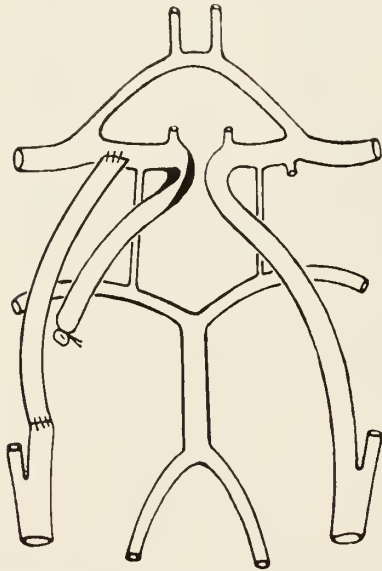


FIG. 2A. Unilateral or bilateral cavernous carotid disease with internal carotid-supraclinoid carotid by-pass graft shown.

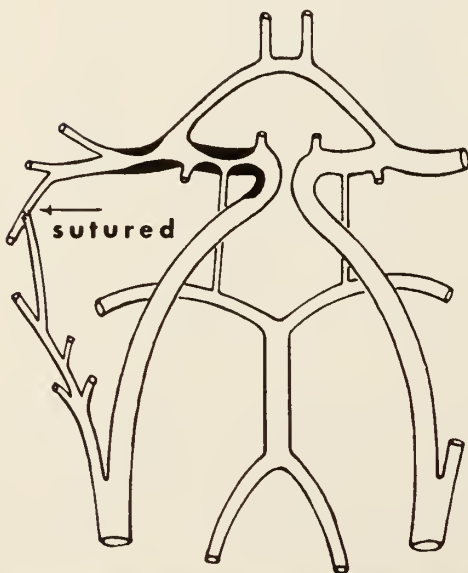


FIG. 2B. Atherosclerotic disease of supraclinoid carotid and middle cerebral artery showing superficial temporal-artery anastomosis.

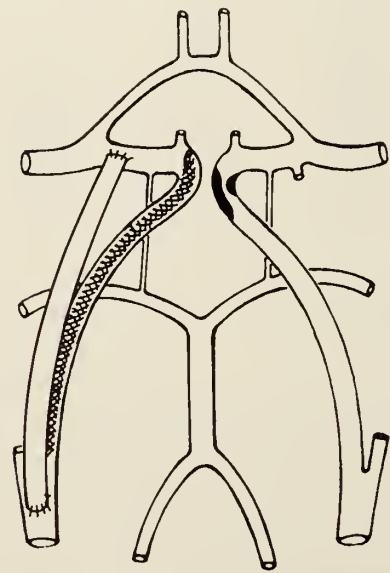


FIG. 2C. With complete occlusion of contralateral internal carotid artery showing common carotid-supraclinoid carotid by-pass graft.

features of the occlusive processes. The role of microsurgery in treatment of these patients is discussed. Careful selection of the patients and the surgical approach are emphasized.

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**LEFT ATRIAL MYXOMAS** may present with signs of mitral valve obstruction, embolic phenomena, or systemic disease. The diagnosis is suspected on clinical grounds and confirmed by angiocardiology. However, the tumor may be unexpectedly discovered on surgical exploration.

Systemic manifestations include fever, weight loss, anemia, increased sedimentation rate, and elevated serum globulins with a left atrial myxoma. These findings are completely reversible after removal of the tumor. Hemodynamic manifestations mimic mitral valve disease although the history may be of short duration. Symptoms may change dramatically over brief periods but may be present for periods of more than 12 years. Once congestive failure occurs, it tends to be progressive and does not respond satisfactorily to medical treatment. Variation in murmurs or symptoms with position or time is almost diagnostic. When postural syncope occurs with other symptoms of mitral obstruction, a tumor should be suspected, for this symptom is rare in mitral stenosis.

Once the diagnosis is established, operation, using cardiopulmonary bypass, should be done promptly. A coexisting valvular lesion should be looked for. Complete cure may be expected, especially if the involved atrial septum is excised and repaired by patch replacement. —Thomas P. Comer, M.D.; Neil R. Arbogast, M.D.; and William R. Schmalhorst, M.D., Bakersfield: *California Medicine*, 118:18-20, April 1973.



# Syphilitic Interstitial Nephritis

C. LAWRENCE DECKER, M.D.; EDWIN J. SMITH, M.D.; AND ON JA KIM, M.D.

WITH THE INSTITUTION of penicillin therapy, the incidence of syphilis and its complications had markedly decreased. However, the present resurgence of syphilis justifies a renewed interest in all phases of the disease. Syphilis as a cause of renal disease and more specifically the nephrotic syndrome has been recognized since the 19th century.<sup>1</sup> It is now commonly included in the etiologic differential diagnosis of the nephrotic syndrome. Diffuse interstitial nephritis, first described by Dr. Arnold Rich,<sup>2</sup> is a less common renal manifestation than the glomerular lesion. A case is reported here of diffuse interstitial nephritis.

## Case Report

A 47-year-old Negro man was admitted to the Cincinnati General Hospital on January 17, 1969. The patient gave a 20-year history of hypertension and a five-year history of an enlarged heart. His admission complaints were shortness of breath, paroxysmal nocturnal dyspnea, ankle edema, weakness, fatigue, and a cough productive of yellow sputum. He admitted to an unknown type of venereal disease as a teenager, which was treated with numerous injections of an unknown drug prior to the penicillin era.

Physical examination on admission revealed a somewhat lethargic male with blood pressure 190/140 mm Hg and pulse rate 88 beats per minute. Arteriolar narrowing was detected on ophthalmoscopic examination. There were bilateral basilar

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rales. No heart murmur, rub, or gallop was heard. The extremities were without edema.

Pertinent laboratory data included hematocrit reading 29 percent; hemoglobin 9.6 gm per 100 ml; white blood cell count (WBC) 8,400 per cu mm with 76 percent neutrophils, 16 percent lymphocytes, and 8 percent monocytes. The blood urea nitrogen (BUN) was 260 and serum creatinine 19.2 mg per 100 ml. The carbon dioxide content was 14 percent; chloride 100 mEq/liter; sodium 140 mEq/liter, and potassium 5.1 mEq/liter. The serum sugar was 130 mg per 100 ml. The urine was clear, pH 5, and contained 3+ protein with no sugar or acetone. The sediment contained no white blood cells, an occasional red blood cell, and an occasional granular cast. A sickle cell preparation was negative. Electrocardiogram showed left ventricular hypertrophy. Calcium was noted in the ascending aorta on the chest x-ray film. Soft tissue x-rays revealed no heavy metal deposition. The 24-hour urinary protein was 1.8 gm per 100 ml, and

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Submitted October 27, 1972.

the creatinine clearance 2 cc per min. The VDRL test for syphilis was weakly reactive. Results of repeat VDRL test and of the Kahn test were negative.

The patient developed a pericardial friction rub, and peritoneal dialysis was instituted. He was subsequently placed in the chronic hemodialysis program in preparation for transplantation. On March 18, 1969, he was readmitted and an elective bilateral nephrectomy was performed on March 19. Coincidentally, a suitably matched cadaver kidney became available eight hours later. The patient was returned to the operating room and a cadaver-kidney transplantation was performed prior to microscopic examination of the patient's kidneys.

On pathologic examination, the left kidney weighed 115 gm and the right 80 gm. Both kidneys were contracted and exhibited a similar appearance. The external surface was pale gray and finely granular with scattered 1-mm retention cysts. On section, the cortex was narrowed, measuring 4 mm in width; corticomedullary demarcation was undisturbed. The medulla was slightly atrophic, and peripelvic fat appeared normal in amount. Thickening of the walls of the small arteries was manifest but focal lesions were inapparent grossly. On microscopic examination, a severe degree of arteriolo- and arterionephrosclerosis was seen, characterized by thick-walled hyalinized afferent arterioles and interlobular and arcuate arteries, in all of which the lumens were markedly narrowed. In consequence, there was widespread ischemic atrophy of all nephron structures. In addition, however, there was evidence of severe, paratubular, interstitial, nodular aggregation of lymphocytes with a curious intratubular herniation. There were distributed throughout the cortex in the main affecting convoluted tubular segments (Fig. 1). The epithelial component exhibited atrophy and degeneration accompanied by intratubular collections of cholesterol and foam cells (Fig. 2).

The patient tolerated surgery with no difficulty and the transplanted kidney has subsequently functioned well. Result of post-transplant VDRL test was weakly reactive, the Kahn test was negative, however, the fluorescent treponema antibody test was positive.

### Discussion

Chronic interstitial nephritis is a nonspecific term used to describe an increased number of interstitial inflammatory cells, fibrosis, and tubular atrophy with only secondary glomerular changes. Yet unresolved is its relation to past infection in the absence of a history of acute pyelonephritis and negative urine cultures. More recently specific etiologies have been demonstrated, especially drug-induced varieties including analgesic abuse. Chron-

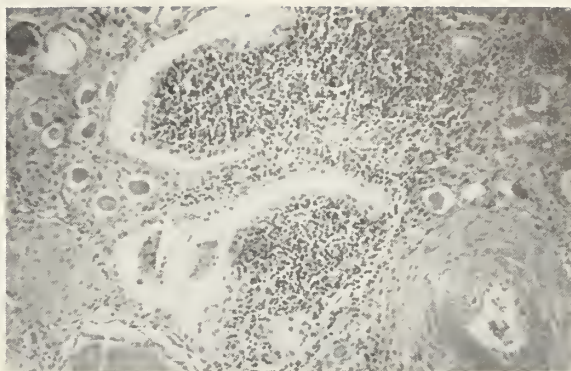


FIG. 1. Renal cortex contains focal paratubular interstitial nodular aggregates of lymphocytes, which herniate into lumens of convoluted tubules.

ic interstitial nephritis can now be subdivided into chronic pyelonephritis, drug induced, gout, calcium or lead poisoning, potassium depletion, irradiation, and others.<sup>3</sup>

Another unusual variety was first described by Arnold Rich<sup>2</sup> in 1932. He attributed 19 cases of diffuse interstitial nephritis, having a typical histologic pattern, to syphilis. All of Rich's 19 cases were in the tertiary stage — nine had had treatment, and 13 of the 19 had associated aortitis. Three of the cases had negative screening serologies. Rich described as characteristic, microscopic renal findings of spherical nodules of lymphocytes herniating into the tubular lumen, with some of the tubules containing cholesterol crystals.

The case presented here had these characteristic microscopic findings. Syphilis had not been considered because of the negative VDRL and Kahn tests. After the pathologist's examination of the kidneys, a fluorescent treponema antibody-absorption test (FTA-ABS) was performed and found to be positive. Careful re-evaluation of the patient's chest x-ray films revealed calcification limited to the ascending aorta, quite characteristic of luetic aortitis.<sup>4</sup> Thus the case reported herein

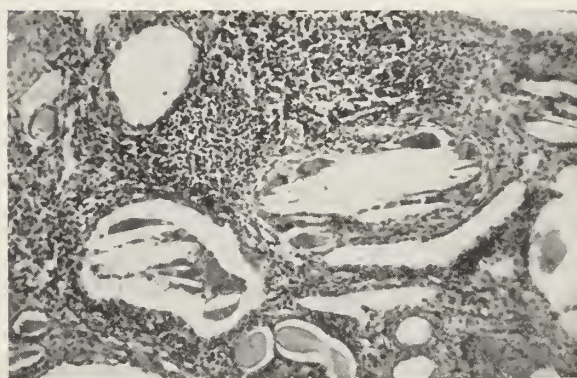


FIG. 2. Nodular lymphoid aggregates are accompanied by tubular epithelial degeneration and intratubular cholesterol collections of detritus and cholesterol.



had other than renal evidence of tertiary lues as did 70 percent of Rich's cases.

Syphilis rarely involves the kidneys. Less than 1 percent of all patients with syphilis have proteinuria.<sup>5</sup> There has been reported recently, however, an increased number of cases of syphilis causing the nephrotic syndrome.<sup>6-11</sup> Immunofluorescent antibody studies of this patient's kidney were negative using fluorescent anti-treponema antibody and fluorescent anti-gamma globulin. Direct fluorescent treponema antibody stains were also negative, thereby failing to reveal the presence of organisms or to detect anti-treponema and antibodies. It should be emphasized that in our case and in three of Rich's cases, despite negative screening serology tests, there was good evidence of luetic renal disease.

### Summary

A case of syphilitic interstitial nephritis is reported. The characteristic findings are nodules of lymphocytes herniating into the tubular lumen and many tubules containing cholesterol crystals. With the increasing prevalence of syphilis, this entity should be considered as a cause of renal disease even in the face of negative serologic screening tests.

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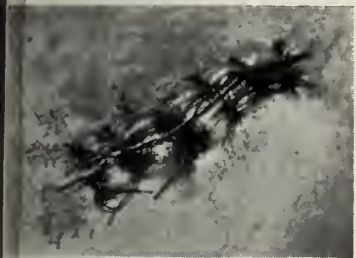
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are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

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# Metastasizing Basal Cell Carcinoma

## Case Report

JAMES W. FUNKHOUSER, M.D., AND ISSARA NA AYUTHIA, M.D.

THE COMMON BASAL CELL carcinoma of the skin is generally considered indolent except in strategic locations where direct penetration can lead to morbidity and, on rare occasion, death. In general, this lesion is not considered one that has a metastasizing potential. That metastases do occur is well documented and this case report will illustrate this condition.

### Case Report

This 77-year-old white female was admitted in September 1971, with a pathologic fracture of the femur. This occurred while she was being assisted to the bathroom by her daughter. Roentgenogram of the right thigh showed a subtrochanteric fracture with radiolucent fragments suggestive of a pathologic fracture (Fig. 1). The surgical biopsy specimen showed a typical pattern of basal cell carcinoma in the metastatic site (Fig. 2). This was treated by intramedullary nailing and external irradiation of 3,000 rads. The presence of a left cheek deformity was noted also. The chest x-ray film was normal.

Past history revealed that the patient was seen in 1950 for a lesion of the left nasolabial area, which was treated by irradiation. In 1963, she was first seen locally by a dermatologist, who treated a large recurrent basal cell carcinoma of the left cheek by electrosurgery and curettage. In 1966, the patient was seen by a hometown physician in Kentucky and a recurrent lesion of the left cheek was re-excised. In 1968, a recurrent lesion of the left cheek was re-excised by a local plastic surgeon. The pathologist's diagnosis at this time was recurrent basal cell carcinoma. In 1969, a radical excision of a recurrent basal cell carcinoma was accomplished by the same surgeon. The tissue showed recurrent basal cell carcinoma. At this time, x-ray films of the face showed no bony involvement.

The patient died of her disease at home six months after our treatment. Autopsy was not performed.

### Comment

Strict criteria for acceptance of a case of metastasizing basal cell carcinoma have been established by Lattes and Kessler<sup>1</sup> in 1951 and Cotran<sup>2</sup> in 1961. The criteria for acceptability are: (1) The primary tumor must arise from skin and not from mucous membrane. (2) Metastases must

be in lymph nodes or viscera. — Involvement of either structure by direct extension is not acceptable. (3) The histopathologic finding in both the primary tumor and the metastases must show the classical form of basal cell carcinoma. The cells must resemble the basal cells of the skin or of the hair matrix and must be uniform and arranged in islands of anastomosing cords showing a distinct peripheral palisading. Intercellular bridges should not be seen and there must be no signs of epidermoid differentiation. Central keratinization is per-



FIG. 1. Roentgenogram showing pathologic fracture of right femur.

missible. Other variations of the basal cell carcinoma pattern (eg, adenoid cystic pattern) are acceptable. It is desirable to have verification of the primary and metastatic tumor by more than one pathologist. Our material was kindly reviewed by Frank W. Foote, M.D., Memorial Hospital, New York, who agreed with the authors' interpretation.

Cotran,<sup>2</sup> after reviewing approximately 9,050 cases of cutaneous basal cell carcinoma, found nine cases with metastasis for an incidence of 0.1 percent. This reported incidence may be high, as the cases are selective in that they were from a large cancer hospital.

The acceptable reported cases reviewed by Hirshowitz and Mahler<sup>3</sup> in 1968 totaled 66 dating from 1894 to 1968. A later review by Wermuth and Fajardo<sup>4</sup> in 1970 brought the number of reports to 76, including their case report. Since then, six additional cases,<sup>5-9</sup> have appeared in the literature, and with this case report, the number of reports will be 83.

The majority of the primary sites reported have been located in the head and neck areas (85 percent).<sup>10</sup> The usual clinical setting is one of long duration of the primary with many attempts at eradication including surgery and/or irradiation. The primary lesions are generally large,

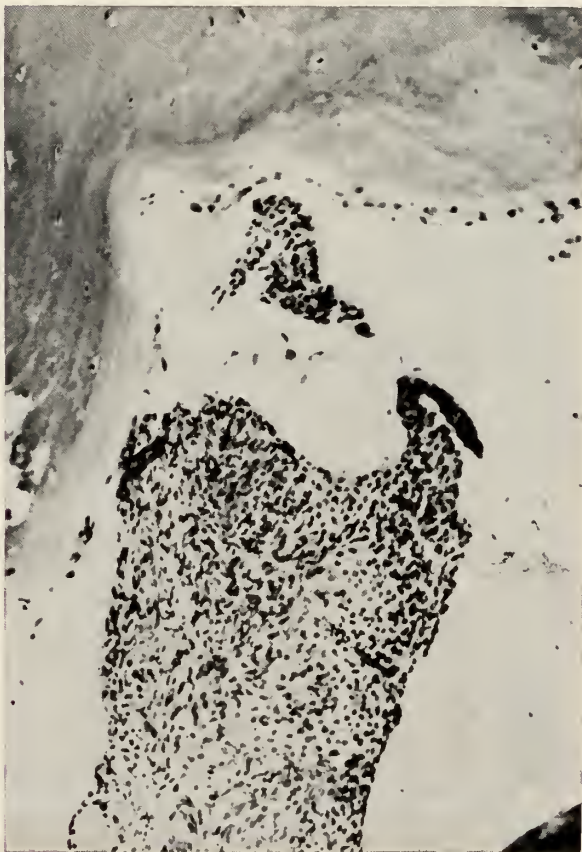


FIG. 2. Section of biopsy specimen showing metastatic basal cell carcinoma to right femur.

## The Authors

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ulcerated with raised borders. In most cases, the primary is obvious, solitary, and present at the time the metastases are recognized.

The commonest location of the metastases has been to regional lymph nodes, followed by lung and pleura, then bone. The current case of bone metastasis brings the total number to 18, or 22.9 percent. The latent period between appearance of the primary skin lesion and the presence of metastasis ranges from 7 to 43 years<sup>3</sup> with an average time of 11 years.<sup>10</sup> There is a male predominance, and with but one exception, all have occurred in whites.<sup>11</sup>

The histology has been reported as showing no difference from the usual classical pattern of basal cell carcinoma except the report of Thomas,<sup>12</sup> where Helwig discusses the metatypical form of basal cell carcinoma. It is this form that Helwig believes more likely to metastasize. The metatypical form shows larger polygonal cells with more eosinophilic cytoplasm and a tendency to lack peripheral palisading.

The prognosis once metastases have occurred is poor. The average survival time after recognition of metastases is ten months.<sup>10</sup> Myelophthitic anemia associated with bone marrow involvement has been reported.<sup>13</sup>

## Summary

We have reported the case of a 77-year-old woman with a 21-year history of basal cell carcinoma of the left nasolabial fold, terminating with metastasis to the right femur and pathologic fracture.

Basal cell carcinomas that metastasize are characteristically large, have been present for many years, and have been refractory to nearly all forms of treatment, as was true in our case. Although a rare complication of this type of cancer, it must be borne in mind in such a clinical setting.

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## Discussion of E.N.T. Case of the Month

(continued from p. 506)

This man has a condition called rhinophyma, which is due to hypertrophy and hyperplasia of the sebaceous glands located in the skin of the nose, giving it an enlarged lobulated appearance. Rhinophyma usually occurs in adult males and may be preceded by long-standing acne rosacea or "rum blossom" nose characterized by multiple acneform lesions surrounded by telangiectasia.

Rhinophyma is treated surgically by excising the redundant tissue (Fig. 2). Some authors advocate resurfacing the nose with a split-thickness skin graft. However, this often results in poor cosmetic appearance, since split-thickness skin will

have a different color and texture from the surrounding nose, and even in the best cases remains as an obvious graft.

A more acceptable method is simply to allow re-epithelialization of the nose to occur. Spontaneous healing in rhinophyma occurs quite rapidly, since following the excision of the redundant tissue, multiple small islets of epithelium remain within the connective tissue and are available as sources of regeneration. This patient's nose was allowed to heal spontaneously by epithelial regeneration (Fig. 3).



FIG. 2. Excess tissue is trimmed.

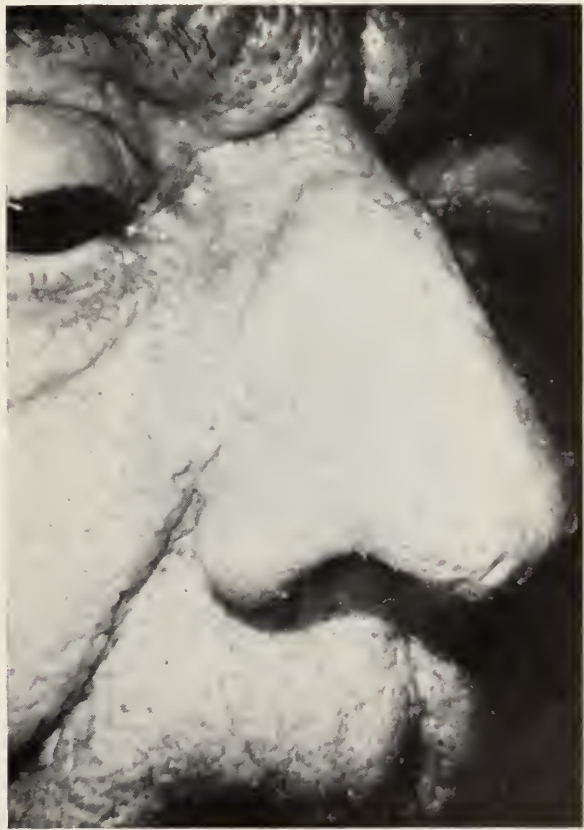


FIG. 3. Raw surface was allowed to re-epithelialize spontaneously.



## Members of the OSMA Council Elected at the 1973 Annual Meeting

AT THE 1973 ANNUAL MEETING of the Ohio State Medical Association, the House of Delegates installed into office the Incoming President, named a President-Elect, a new Secretary-Treasurer and one new Councilor, and reelected four Councilors. Following are brief biographical sketches of the President-Elect, the Incoming President, Secretary-Treasurer, the new Councilor, together with additional information on other members of The Council.

Dr. James L. Henry, of Grove City, was named President-Elect of the Association and will be installed as President at the 1974 Annual Meeting in Cleveland. He is a general practitioner in Grove City, is on the staff of Mt. Carmel Hospital, Columbus, and served for more than 12 years as chairman of the Mt. Carmel Department of General Practice.



James L. Henry, M.D.

His activities in medical organization work have been numerous. As a member of the Academy of Medicine of Columbus and Franklin County, he has served that organization as Secretary-Treasurer (1954-1958), as President-Elect (1958) and as President (1959). He has also served on a number of committees of the Academy. He was chairman of the Utilization and Review Committee, the Medical Services Committee, and the Family Practice Committee, and was a member

of the Professional Relations Committee and the Academy representative to the Press Code Committee.

Dr. Henry was elected Treasurer of the Ohio State Medical Association in 1967, an office which has since been changed to Secretary-Treasurer, and he was reelected in 1970.

After careful planning and analysis, The Council in 1971 established the Medical Advances Institute (MAI), and Dr. Henry was elected its first President. This is the Ohio organization that is responsible for development of Professional Standards Review Organizations (PSRO) in Ohio. Dr. Henry has traveled extensively, speaking in behalf of this concept, and has appeared before hearings in Washington on its behalf. He has also written a number of articles for publication on peer review and utilization review.

The new President-Elect is a native of Spokane, Washington, but lived much of his early life in Grove City where he graduated from high school. He received his Bachelor of Arts degree from Ohio State University and his medical degree from the OSU College of Medicine in 1944. After an internship at the former St. Francis Hospital, Columbus, he entered military service, and attained the rank of Captain before his release from active duty in 1947. Among assignments during the war, he was chief of the Outpatient Service at Camp Kilmer, New Jersey.

Since serving on The Council, he has served on the OSMA Peer Review Committee, Building Committee, and several other committees of the Association.

He is a member of the American Medical Association, the American Academy of Family Physicians and the Ohio Academy of Family Physicians.

Dr. Henry is married to the former Virginia Hysell, and the couple has two children, a son James, and a daughter Diane.

### Incoming President

Dr. Oscar W. Clarke was installed as President of the Association at the final session of the House of Delegates and assumed office at that time. He was named President-Elect at the 1972

Annual Meeting in Cincinnati after serving on The Council since 1966 as Councilor of the Ninth District.

Dr. Clarke is a practicing physician in Gallipolis, specializing in internal medicine and is a diplomate of the American Board of Internal Medicine. He is chief of internal medicine on the Holzer Medical Center Hospital staff, is vice-president of the staff, and a member of the Hospital's Board of Trustees.



Oscar W. Clarke, M.D.

Since becoming a member of the Council, he has served as chairman of the OSMA Auditing and Appropriations Committee, the OSMA Liaison Committee with the Ohio State Bar Association, the OSMA Scientific Exhibit Evaluation Committee, and the OSMA Advisory Committee to the Woman's Auxiliary.

Other statewide responsibilities include those as trustee of the Medical Advances Institute, as member of the OSMA Hospital Relations Committee, OSMA Workmen's Compensation Committee, OSMA Membership and Planning Committee, OSMA Joint Coordinating Health Planning Committee, and OSMA representative to the Professional Relations Committee with the Ohio Hospital Association. He was named by the House of Delegates as Alternate Delegate to the American Medical Association, effective in 1970, and was elected Delegate beginning in 1972.

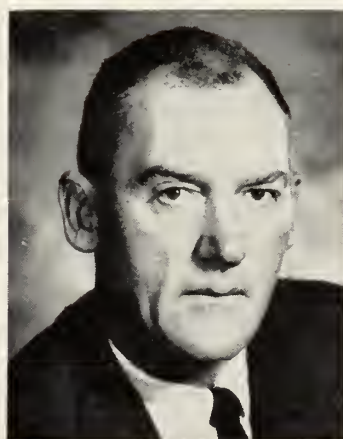
He is a past president of the Gallia County Medical Society, a former trustee of the Central Ohio Heart Association, a past president of the Gallia County Heart Branch, and a former vice-president and former trustee of the Ohio Society of Internal Medicine. Dr. Clarke is a Fellow of the American College of Physicians, and a Fellow of the Royal Society of Medicine. He is a member of the American Heart Association, the American Federation for Clinical Research and the American Association for the Advancement of Science.

In civic and community affairs he has been equally active. Among positions of honor, he has been president of the Gallipolis City Board of Health, president of the local Rotary Club, president of the Tri-County Community Concert Association, and vice-president of the Tri-State Regional Council for Boy Scouts. He has been a director of the Community Improvement Corporation, a member of the local City Planning Commission, a member of several historical societies, art groups, and nature and outdoor organizations.

A native Virginian, he attended Randolph Macon College, and received his medical degree from the Medical College of Virginia in 1944. After an internship at Boston City Hospital and some residency training, he entered military service in the U. S. Air Force and was assigned as chief of medicine at a station hospital in Germany. Dr. Clarke is affiliated with several fraternal organizations and is an Elder in the First United Presbyterian Church of Gallipolis. He is married to the former Susan Frances King, and has three daughters and a grandson.

#### Secretary-Treasurer

The House of Delegates elected Dr. William M. Wells as Secretary-Treasurer for a three-year term to succeed Dr. Henry in that office. Dr. Wells is a general practitioner in Newark and has served six years on The Council as Councilor of the Eighth District.



William M. Wells, M.D.

Dr. Wells is a native of Columbus, took his undergraduate work at Ohio State University and received his medical degree from the OSU College of Medicine in 1942. He continued his work at University Hospital in Columbus for his internship before entering military service.

As a Medical Officer in the Army during World War II he was on active duty for three years and attained the rank of major.

After the war he took a year's residency train-



ing in surgery and opened his practice in Newark in 1949.

He is on the senior staff of the Licking County Memorial Hospital and former chief of staff. Also he formerly served for six years on the hospital's Board of Trustees, and recently was again elected to the Board.

He has worked in numerous capacities for the Licking County Medical Society and is a Past President of that organization. He formerly served as a member of the Board of Directors of the Executive Committee of the Citizens Council for Health and Welfare in his area.

Dr. Wells was first appointed to The Council in September 1967 to fill part of an unexpired term and was subsequently reelected to that office by the House of Delegates. Since being on The Council, he has served on several committees, among them the Committee on Care of the Aged, Committee on Government Medical Care, the Committee on Industrial Medicine, the Committee on Membership and Planning, as chairman, and the Advisory Committee to the Ohio State Society of Medical Assistants of which he is chairman.

He is a member of the Board of Directors of Ohio Medical Indemnity, and a member of the OMI Executive Committee.

Dr. and Mrs. Wells have three sons and a daughter.

#### **Eighth District Councilor**

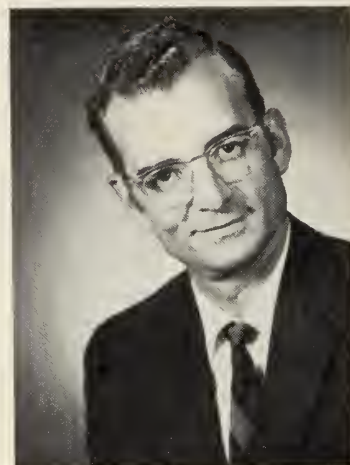
The House of Delegates elected Dr. Richard E. Hartle, of Lancaster, as Councilor of the Eighth District to succeed Dr. Wells in that office.

Dr. Hartle has been in private general practice in Lancaster since 1964, currently in partnership with Dr. James E. Key. He is a Diplomate of the American Board of Family Practice.

A native Ohioan, Dr. Hartle took his undergraduate work at Ohio State University and received his M.D. degree from the OSU College of Medicine in 1958. He then went into military service, took his intern training at the Brooke Army Hospital in San Antonio, Texas, and went overseas where he served as a Preventive Medicine Officer for an Infantry Division in Germany. Upon returning to civilian life, he took residency training in family practice at the Riverside Methodist Hospital, Columbus, before going into practice.

An active participant in the Fairfield County Medical Society, he was elected vice-president of that organization for 1968 and was again elected to that same office in 1973. He was also elected an alternate delegate to the OSMA House of Delegates and served as delegate in 1969. Later he was elected as a delegate and served from 1971 to the current year. He is a member of the American Academy of Family Physicians, the Ohio Academy

of Family Physicians, and the Fairfield County Academy of Family Physicians. He is a past president of the local organization and is currently serving as its secretary-treasurer.



**Richard E. Hartle, M.D.**

Dr. Hartle is a member of the Lancaster City Board of Health and has been its president pro tem since 1970. Also he is a member of the Fairfield County Branch of the American Heart Association and was its president in 1966.

Other affiliations include membership in the Association of American Physicians and Surgeons, the Lancaster Area Chamber of Commerce Board of Directors, the First Presbyterian Church of Lancaster and the Masonic Lodge. Dr. Hartle is married to the former Myrna M. Knight and the couple has four children.

#### **Other Members of The Council**

Dr. William R. Schultz, of Wooster, as Immediate Past President, will serve an additional year on The Council.

Reelected Councilors for additional two-year terms are Dr. James G. Tye, Dayton, Second District; Dr. George N. Bates, Toledo, Fourth District; Dr. Maurice F. Lieber, Canton, Sixth District; and Dr. James C. McLarnan, Mt. Vernon, Tenth District.

Councilors in the midst of two-year terms are Dr. Stephen P. Hogg, Cincinnati, First District; Dr. John C. Smithson, Findlay, Third District; Dr. Robert E. Rinderknecht, Dover, Seventh District; Dr. Thomas W. Morgan, Gallipolis, Ninth District; and Dr. Robert G. Thomas, Elyria, Eleventh District. Dr. David Fishman, Cleveland, who was serving as Fifth District Councilor, died suddenly on May 22 shortly after the Annual Meeting.



## “Up with Medicine – Part Two”

By WILLIAM R. SCHULTZ, M.D., President  
Ohio State Medical Association

Members of the House of Delegates, Distinguished Past Presidents, Distinguished Guests, Ladies and Gentlemen:

WHEN I WAS INSTALLED in this honorable office at the close of the 1972 Annual Meeting, I proposed an “Up with Medicine” campaign. In that inaugural proposal, I concluded:

“There is so much to be achieved and so little time to do it. We can ill afford to dissipate our energies in small groups of regional philosophical self-interests. To do so subverts too much energy from our principal goal . . . and, as always and forever, that goal is . . . the best medical and health care for all the people.”

In the past year, we have seen a kaleidoscope of changes and developments in medicine.

We have seen professional services review organizations become the law of the land, as OSMA predicted and anticipated, and for which OSMA prepared.

We have seen some definite soul-searching by many of the more vocal advocates of nationalized medicine.

We have seen serious proposals by the national administration to curtail or to cancel out entirely certain health programs which we found to be wasteful, ineffective, unnecessary—or all three.

We have seen development of a serious plan to “kick the H” out of HEW and establish a federal U.S. Department of Health at the cabinet level—a move medicine has been advocating for more than a century.

We have seen the public, the politicians and the news media turning more and more to medicine for “the answers.”

In essence, what we have seen is a turning away from the nonmedical health care “experts” and a turning toward the medical profession for guidance and for leadership in the health care field.

As doctors, we are trained to look at the vital signs and the symptoms. In applying this training to the health care field in the past year, I think the patient has taken a turn for the better.

I quickly want to warn you, however, that this is only the beginning. It is not an avalanche, it is not a groundswell, it is not a tidal wave. But it is a very real and very definite beginning. Our job, now is, to help this movement to grow and to accelerate.

One of the most difficult aspects of being President of the Ohio State Medical Association is being caught up in so many swiftly moving events and so much program development.

I wish I could sit down for two or three hours with every individual in this House of Delegates—as long as I am wishing, I might as well make it every member of OSMA—and talk about what is happening in OSMA and what is happening in health care. However, I would like to discuss a few of the main issues.

### National Health Insurance

First is the question of a national health insurance program.

On March 13, the *Wall Street Journal* reported, “UAW admits the steam has gone out of the drive, spearheaded by labor, for legislation to create a national health insurance program. United Auto Workers President Leonard Woodcock notes that labor-supported “health security” bills have fewer backers in both the Senate and House this year than in 1972.”

I am happy to say AMA’s Medigap bill is more than holding its own.

We have seen the Ohio news media editorially thrash the Ohio Department of Public Welfare for its Medicaid payment fiasco. Not too long ago, the doctors would have been blamed for the Medicaid mess. Now the blame is being placed where it belongs.

We have seen the publication and serious acceptance of a most significant book: “*The Case for American Medicine; A Realistic Look at Our Health Care System*.” This book, by Harry

Schwartz, distinguished *New York Times* editorialist and columnist, should be required reading for every member of Congress and for every medical student. If you have not read it, I urge you, I beg, I implore you to read it without delay. This book should help preserve the present system of private medical care.

### Attitude of News Media

There has developed in the past year a very definite and very positive change of attitude within the news media. More editorials are asking:

"Do we really need to revolutionize health care?"

"Perhaps the politicians would do well to listen more to the doctors."

"Can the United States really afford 'free' (and I emphasize quotes around free) health care for all?"

"What are the motives of the highly vocal advocates of a federal health care system?"

"If the doctors are doing such a bad job, how come people are living longer, healthier lives in the United States?"

I can think of no greater chances of success in preserving what we must preserve in our medical care system than in having thinking, intelligent persons asking questions such as those. More and more Americans are turning and returning to medicine for leadership and for answers. We absolutely must provide that leadership. We absolutely must continue to give them the answers.

We can never be afraid of questions and honest answers if we are to survive.

### PSRO Developments

For example, a major question before this House of Delegates in 1972 was Medical Advances Institute—MAI. Resolution after resolution questioned MAI. That was good. The House examined the question, weighed and judged the answers, and concluded that MAI was a good and necessary arm of OSMA.

This House, after considerable discussion at the 1972 meeting, directed the establishment of a peer review organization, whose function would be to set up an umbrella of broad general guidelines to coordinate the review activity of component organizations and to act as arbitrator in disputes arising from review done at the local level.

This has been done during the past year, under MAI, through the enthusiastic support of nonmedical health care providers and insurers and through the generous donation of time and energy by some 260 members of OSMA, who gave over twenty thousand man-hours of time.

All of medicine owes a deep debt of gratitude to these men and to the Past President of MAI, Jim Henry, who worked so diligently to carry out the direction of this House. These labors have resulted in the formation of a computerized system for peer review done by physicians at the local level under a statewide umbrella also controlled by physicians.

More advanced in scope and so much less expensive per unit than any now contemplated or in operation, our system is being widely studied by many states.

In order that we avoid the quality assurance program (QAP) of the American Hospital Association, which is hospital, not staff, oriented, and the FLAP of every other nonphysician controlled plan of peer review, PSRO under MAI must become the statewide plan and be permitted to enter into contracts with third parties.

Peer review of Medicare and Medicaid patients by an acceptable peer review organization is now law. Peer review is and always has been an established mechanism for the assurance of the quality of medical care, long before consumerism under Nader became popular. With unified peer review under MAI, we can, at last, have facts to back up our claims of quality care—

We can refute the emotional charges hurled at us by the social planners who would replace a working system with an untried nonsystem—

We can uphold, by the submission of fact, the action of our fellow physicians and bring down the frequency and cost of malpractice action—

We can reinforce our continuing education program.

Being a physician in private solo practice, I feel I share with everyone here all the frustrations and pent-up feelings regarding government intrusion into medicine. I want my peer review done by fellow practicing physicians, not by hospital personnel—not by state health department personnel—not by welfare department personnel—or not by HEW personnel. I want it done by PSRO under MAI where my peers truly act, not in the interest of a third party or an individual physician, but in the interest of the quality care given all patients. There is no way to go except together. Let us continue to move together in the best interest of good medicine and our patients.

### Fair Fee Concept

Another major question put before this House through various resolutions last year was Ohio Medical Indemnity's "Hold Harmless" contracts. Again, the House asked, the House listened to the answers, the House examined and the House acted. The result was that, with some modifications requested by the profession, these contracts were,



with House approval, continued under the "Fair Fee" concept. A .700 batting average is outstanding in any league.

### Medical Political Action

Another medical profession activity was significantly successful in Ohio this year. That is OMPAC—the Ohio Medical Political Action Committee. Eleven of the 12 OMPAC-supported candidates for the U.S. House of Representatives were winners, 48 of the 73 OMPAC-supported candidates for the Ohio House of Representatives were winners, and 12 of the 16 OMPAC-supported candidates for the Ohio Senate were winners.

I am proud to report that a member of this House of Delegates, Dr. Jack Lewis, is now chairman of the American Medical Political Action Committee.

Two projects directed by the 1972 House of Delegates have been carried out and the results are in your delegate handbooks for consideration at this 1973 session.

One is the preparation of a prototype for a statewide medical care foundation. This prototype was prepared by the American Health Systems, Inc., under contract with OSMA, and will be considered for action by this House of Delegates.

### Continuing Medical Education

Another project directed by the 1972 House has been carried out and the results reported back for consideration at this session. I am referring to the survey of continuing medical education activities of OSMA members. Our Commission on Medical Education completed this most detailed study and report, and is to be highly complemented for the excellence of its work. The survey report has drawn much attention throughout the United States and Canada.

I urge all delegates to give full and careful consideration to both reports, and to act on them at this session.

### Aid to Specialty Societies

In June, 1972 two members of the OSMA Staff visited the Texas Medical Association to examine and learn about a system instituted in Texas whereby the state association provided certain membership and financial services to Specialty Societies.

In September of 1972 the OSMA Council approved a system and working agreement to be used in contracting with Specialty Societies in Ohio. The services offered are on a cost basis at no profit or cost to OSMA.

At the present time services are being performed for the following organizations: (1) Ohio

Ear, Nose and Throat Society, (2) Ohio Society of Internal Medicine, (3) Ohio Neurosurgical Society, (4) Ohio Ophthalmological Society, (5) Ohio Society of Pathologists, (6) Ohio Committee on Trauma, American College of Surgeons. Contact has been made and interest exhibited from the Ohio Society of Allergy and Immunology and the Ohio Chapter, American College of Surgeons.

### OSMA Headquarters Building

Another positive development in the past year was the start of construction of an OSMA headquarters building. Escalating costs of downtown office rentals plus space needs for expanded and additional OSMA activities dictated this move. I hope the next Annual Meeting in Columbus will feature a tour of the completed headquarters building being constructed just a few blocks south of Interstate 70 on South High Street.

Now, before we start patting ourselves on the backs and bragging about what a great job we have been doing, there are some negatives to be called to your attention.

### Parable: The Three-Legged Stool

I think we must become actively concerned in Ohio when only 7,215 of the approximately 15,000 nonfederal physicians in the state are dues-paying AMA members. Even when we subtract some 2,700 interns and residents from that 15,000, we still find a tremendous potential for increasing membership in and support of the AMA.

I here and now personally call on and appoint every member of this House of Delegates as a task force to induce our non-AMA colleagues to demonstrate their allegiance to the one and only national voice that speaks for **all** of medicine. The only way they can do this is by joining the AMA.

We also must give serious attention to Ohio State Medical Association membership. Our 1972 total membership was 10,365. Again, discounting the some 2,700 interns and residents in Ohio, we still have a tremendous membership potential. Certainly, some of those 2,000 non-OSMA physicians must include a number eligible for membership.

This House of Delegates will consider amendments to the Bylaws which would open the door to county society and OSMA membership for physicians in accredited training programs. I hope the House will act favorably on those proposals.

Your OSMA Membership and Planning Committee has concerned itself with these membership problems. The solution, however, requires more than the work of this committee.

Therefore, I recommend and I urge that every County Medical Society and every Academy of Medicine immediately organize a strong, active,



blue-ribbon committee charged with the responsibility of soliciting the membership of **qualified** non-member physicians in the local societies, in OSMA and in AMA.

Members of the House, I cannot emphasize too strongly the paramount importance of the fact that organized medicine is like a three-legged platform. One leg is the most important—that is the county medical society—the anchor leg. However, without both of the other two legs—the Ohio State Medical Association and the American Medical Association—the platform will topple.

Medicine is well beyond those golden years when physicians automatically applied for local, state and national membership in their professional associations. We in organized medicine must welcome, we must invite, we must recruit **qualified** physicians into this tripartite membership. We must be “salesmen” for our professional organizations and we must have confidence in what we are selling.

It is ironic that the organizations that have so well represented the medical profession for more than 125 years now find their voices being weakened and their support eroded at a time when medicine never needed a stronger, more unified voice.

It is tragic that, in these times when medicine faces so many challenges to its very independence, more and more physicians are staying away or deserting the only organization that can speak for the entire profession locally, state and nationally.

I would like to see the organization of effective local committees, and I would like to see each Councilor District report to the 1974 House of Delegates the activities of these committees and the results. I herewith recommend such a Councilor District report to the House on an annual basis.

### Challenging a Network Hoax

One of the best examples of the effectiveness of the triangle of organized medicine is the story of that NBC travesty of December 19, 1972, a telecast entitled “What Price Health?” The Cleveland Academy of Medicine, the Ohio State Medical Association and the American Medical Association worked closely and effectively to expose nationally a hoax in that telecast. The hoax was the case of a little Cleveland girl who was represented by NBC as about to die because her parents lacked funds for heart surgery.

The local, state and national organizations, working together, immediately established the fact that this little girl had outstanding medical and surgical care, that medical insurance paid for her operations, that the Ohio Crippled Children program would have provided funds, as would Aid

to Dependent Children. Her father, unemployed at the time of the filming last summer, was called back to work in September, and health insurance paid for a successful operation performed in November. In December, NBC told the American people, using the Cleveland case as an example, “. . . if you can't afford to live, you die.”

Our exposure of this hoax may well lead to federal legislation fixing greater responsibility on the broadcast networks for accuracy and fairness. It is not asking too much to expect the network to operate under the same jurisdiction and regulations as do the local stations.

### Strength—By Working Together

Another example of the strength of organized medicine's triad is the Medcredit bill. Here again, AMA, this Association and its county societies have obtained more Congressional sponsors for Medcredit than has any other state. How? By working together.

I don't want to belabor the importance of our local-state-national structure and the importance of getting the membership of every eligible physician, but I must point out some numerical facts of life.

We physicians are a very, very small minority of the total population. Our past and present successes are made possible only by unity. We can't afford the nonjoiners and the organizational dropouts. Why? A few years ago, a staffer of the OSMA was testifying before an Ohio General Assembly Committee. He introduced himself as representing OSMA, a statewide organization of more than 10,000 doctors of medicine. The committee was duly impressed. Our staffer was followed by a witness taking the side opposite from our position on the proposed legislation. He introduced himself as representing a Cleveland labor council and its more than **on hundred fifty thousand members**. I can think of no better illustration to prove that all doctors of medicine—each and every one of us—must pull together locally, statewide and nationally.

There is a saying on Congressional Hill that is most appropriate: “The banana that leaves the bunch gets skinned.”

In preparing this traditional President's Address, the temptation to dwell on nothing but my own personal enjoyment and experiences was almost too much.

### Change with “Reason and Meaning”

Permit me, however, to indulge this temptation just a bit.

First, is an observation over many years of the wisdom displayed by this House in establishing

policy only after careful study and debate of any resolution. This gives me great confidence in the future of medicine—change with reason and meaning, not for the sake of change alone. Thank you for your dedication and for granting me the privilege of serving as President this past year.

One experience I always will appreciate is working closely with The Council. These men are too often unappreciated for the tremendous contribution they make. How many of you realize that, in the interim between the 1972 session and this Annual Convention your Councilors spent 18 days in hard-working weekend meetings. Add to this four days for this meeting plus the numerous meetings your Councilor has with his District Societies. The result is that the OSMA Councilor gives about 35 days a year—one tenth of his time—as a tithe to his profession. This does not include the hours of reading, committee reports, staff reports and background information necessary for each of these meetings. Thank you, Council, for your support in past years.

### Working Together

Another group that deserves more recognition and appreciation is the Woman's Auxiliary. In the past year, for example, we helped them set up a statewide speakers program and conducted for Auxiliary leaders a two-day seminar on public speaking. Their enthusiasm, abilities and dedication deserve the whole-hearted support of every physician. Thank you, Woman's Auxiliary, for your generous contributions during this past year.

Without our OSMA committees we would be unable to function. The work put out by our more than 25 active committees is absolutely fantastic. You won't find a more involved, more dedicated group of physicians anywhere. Thank you, com-

mittee members, for all you have done for OSMA this past year.

My personal thanks, as well as conveying the thanks of all our members, to the finest medical organization staff in this country. Thank you Hart, Chuck, Herb, Jerry, Bob, Dave, Katherine, Gordon, Gail, Carol and all the secretarial staff. Without your devoted effort, it would be impossible to carry out the work of this organization this past year. All this, plus the support of my associates in the Wayne County Medical Society and the understanding, tolerance and support of one Helen Schultz, have made this past twelve months one of the most rewarding, most eventful and most interesting years in my medical career.

At the "alpha" of my term as president of this Association, I proposed, "We are all in the same boat, so let's grab an oar and start rowing in the same direction."

Here at the "omega" of my term, I am so deeply grateful to report to you the conviction that more and more physicians in our Association and others in the health field are "pulling oars" in the same direction. This is not just wishful thinking. It is fact.

I concluded my inaugural talk in 1972 with a statement. Based on my experiences in the past 12 months, I will now conclude these remarks with that identical statement, but with even more conviction and determination. That statement was and is:

"There is so much to be achieved and so little time to do it. We can ill afford to dissipate our energies in small groups of regional or philosophical self-interests. To do so subverts too much energy from our principal goal . . . and, as always and forever, that goal is . . . the best medical and health care for all the people."

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| 2                       | <b>Departments of Family Medicine</b> (not introduced)<br>(Perry County Medical Society)   |  | 20                      | <b>Medicine and Religion Academic Curriculum</b><br>(Richard L. Fulton, M.D., Delegate, Academy of Medicine of Columbus and Franklin County)                               | No. 4  |
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| 12                      | <b>Departments of Family Medicine</b><br>(Academy of Medicine of Cleveland)  | No. 2  | 30                      | <b>Ethical Status of Provider Agreement</b><br>(Ross County Medical Society)   | (to the Council)                                     |
| 13                      | <b>Abortion as a Medical Procedure</b><br>(Academy of Medicine of Cleveland)   | No. 2  | 31                      | <b>Departments of Family Medicine</b><br>(Lima and Allen County Academy of Medicine)   | No. 2  |
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| 17                      | <b>The Ohio Medical Indemnity</b><br>(Ross County Medical Society)   | No. 4  |                         |  |  |
| 18                      | <b>Discrimination Against Physicians</b><br>(Ross County Medical Society)  | No. 3  |                         |  |  |



| Resolution<br>No. . . . | Subject and Sponsor   | Referred to<br>Resolutions<br>Committee<br>No. . . . | Resolution<br>No. . . . | Subject and Sponsor   | Referred to<br>Resolutions<br>Committee<br>No. . . . |
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**Note:** This index is for reference purposes only, and is not a part of the Official Proceedings of the House of Delegates.

# Proceedings of the House of Delegates 1973 Annual Meeting

## MINUTES OF FIRST SESSION

**T**HE FIRST SESSION of the House of Delegates of the Ohio State Medical Association was convened at 7:00 p.m., Sunday, May 6, 1973, at the Sheraton-Columbus Hotel, Columbus, with President William R. Schultz, Presiding.

The death of Dr. Horatio T. Pease, Wadsworth, OSMA President, 1963-1964, was announced after which a moment of silence was offered.

The Invocation was offered by Dr. Charles A. Sebastian, of Cincinnati.

Dr. Ben Arnoff, President of the Academy of Medicine of Columbus and Franklin County welcomed the delegates and guests to Columbus.

Dr. Raymond T. Holden, Washington, D.C., American Medical Association Trustee, brought greetings from the AMA and discussed ongoing AMA programs.

Dr. John W. Cashman, Columbus, Director of the Ohio Department of Health, addressed the House and told of the work and plans of his agency.

## Report on Delegates Present

Dr. Robert B. Elliott, Ada, Chairman of the Credentials Committee, reported 161 delegates seated and eligible to vote. A number of alternate-delegates, guests, officers of county medical societies, and executive secretaries were in attendance.

## 1972 Minutes Approved

The minutes of the 1972 sessions of the House of Delegates, as published in the July, 1972, issue of *The Ohio State Medical Journal*, were approved by official action.

## Introduction of Guests

Dr. Schultz introduced the following honored guests:

Mr. William Culbertson, Bowling Green, Chairman of the Board, Ohio Hospital Association; Mrs. Sandra Bennett, Columbus, Assistant Executive Director, Ohio Nurses Association; Ru-

dolph Janata, Jr., LLB, Columbus, President, Ohio State Bar Association; Dr. David M. Drenan, Tallmadge, President, Ohio Veterinary Medical Association; Dr. Harry A. Killian, Willoughby, President, Ohio Academy of Family Physicians; Mrs. Louis Loria, Bristolville, President, Woman's Auxiliary to the Ohio State Medical Association; Mrs. Karl Ulicny, Salem, President-Elect, Woman's Auxiliary to the Ohio State Medical Association; Dr. W. J. Lewis, Dayton, Chairman of the Board, American Medical Political Action Committee; Dr. H. William Porterfield, Columbus, Chairman of the Board, Ohio Medical Political Action Committee; and Mr. Bernard King, Columbus, President, SAMA Chapter, Ohio State University College of Medicine.

## OSMA Past Presidents Introduced

The following Past Presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. H. M. Clodfelter, Columbus; Dr. Richard L. Meiling, Columbus; Dr. Robert S. Martin, Zanesville; Dr. Frank H. Mayfield, Cincinnati; Dr. George W. Petznick, Cleveland; Dr. Robert E. Tschantz, Canton; Dr. Henry A. Crawford, Cleveland; Dr. Lawrence C. Meredith, Oberlin; Dr. Robert E. Howard, Cincinnati; Dr. Robert N. Smith, Toledo; Dr. Richard L. Fulton, Columbus, and Dr. P. John Robeck, Cleveland.

Also introduced were former members of the Council: Dr. Chester H. Allen, Portsmouth; Dr. Dwight L. Becker, Lima; Dr. Philip B. Hardyman, Columbus; Dr. J. P. McAfee, Portsmouth; Dr. Paul F. Orr, Perrysburg; Dr. Sanford Press, Steubenville; Dr. George J. Schroer, Ft. Loramie; Dr. George Newton Spears, Ironton, and Dr. Edwin R. Westbrook, Warren.

## President's Medallion Presented

Dr. Robeck was introduced for the presentation of the newly designed President's Medallion to Dr. Schultz.

## Thanks Expressed

Dr. Schultz expressed the thanks of the Ohio State Medical Association to Dr. Jack E. Tetrick,

Chairman, and to the members of the Committee on Scientific Work for their contributions in planning the 1973 meeting.

### Other Guests Introduced

Dr. John H. Budd, Cleveland, AMA Board of Trustees; Mr. James S. Imboden, Columbus, Assistant Director, Department of Field Service, AMA Division of Public Affairs; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Mr. Charles S. Nelson, Columbus, Retired OSMA Executive Secretary and Honorary Member of OSMA, and Mr. George H. Saville, Columbus, Retired OSMA Executive Secretary and Honorary Member of OSMA.

### Report of Woman's Auxiliary President

Mrs. L. A. Loria, Bristolville, President of the Woman's Auxiliary to the Ohio State Medical Association, was escorted to the podium by Dr. David Fishman, Cleveland, Fifth District Councilor, and Chairman of the Woman's Auxiliary Advisory Committee. Mrs. Loria reported on Auxiliary activities during her administration, with special emphasis on the Legislative program. (See page 566).

### AMA-ERF Checks Presented

The following representatives of Ohio's Medical schools received American Medical Association Education and Research Foundation checks from Dr. Philip B. Hardymon, Chairman of the Ohio Committee for the American Medical Association's Education and Research Foundation.

Dr. David Fishman for Case Western Reserve University School of Medicine, Cleveland. (Check for \$8,542.22)

Dr. Richard Ruppert, Assistant Dean, The Ohio State University, College of Medicine, Columbus. (Check for \$14,362.08)

Dr. Robert S. Daniels, Interim Dean, University of Cincinnati College of Medicine, Cincinnati. (Check for \$15,778.79)

Dr. Robert G. Page, Dean, Medical College of Ohio at Toledo, Toledo. (Check for \$3,531.56)

### Plaques and Certificates of Appreciation

The following received plaques in appreciation for their service to the Association: Dr. P. John Robeck, Cleveland, and Dr. Dwight L. Becker, Lima, as retiring members of the Council.

A certificate of appreciation was presented to Dr. Robert E. Zipf, Dayton, for his service as Chairman of the Standing Committee on Scientific Work.

Dr. Robert E. Howard, Cincinnati, Committee on Public Relations, also received a certificate.

The following retiring chairmen of special committees were honored: Dr. Drew L. Davies, Columbus, Military Advisory Committee; Dr. H. William Porterfield, Columbus, Committee on Government Medical Care Programs, and Dr. P. John Robeck, Cleveland, Ohio Medical Indemnity Liaison Committee.

### Presentation of Distinguished Service Citation

Dr. Elizabeth Rowland Aplin, Columbus, was named the recipient of the Distinguished Service Citation. This citation is in recognition of her outstanding contributions to Ohio medicine as Director of Ohio Services for Crippled Children and for her work in the field of school health. Dr. Aplin was unable to be present and in her absence had requested that her son and daughter-in-law, Charles II and Patricia accept the citation from Dr. Schultz. Mr. Aplin addressed the House in behalf of his mother.

### Presentation of Special Awards

Dr. Schultz presented to Dr. Howard S. Madigan, Toledo, a special award for his significant contribution to the medical profession of Ohio through his design, compilation and comprehensive analysis of a survey of continuing education activities of the membership of this Association.

Dr. Frank L. Shively, Jr., Dayton, was honored by the House for his leadership as the Chairman of the Board of Directors of Ohio Medical Indemnity, Inc. (1969-1973) and for his dedication to the advancement of Physician/Blue Shield relations in Ohio. Dr. Shively addressed the House.

### Awards Presented by Student American Medical Association

Russell A. Test, Vice-President, Projects and Activities of the Student American Medical Association Chapter, University of Cincinnati College of Medicine, presented the following awards for assistance in the Medical Education and Community Orientation (MECO) summer projects: Dr. William R. Schultz (accepting for the OSMA), and to Mr. Robert D. Clinger for "his invaluable personal assistance and time" in helping MECO.

### Twenty-Five Years' Service Award

Mr. and Mrs. R. Gordon Moore were escorted to the rostrum where Mr. Moore was honored for his 25 years of service to the Association, as Executive Editor and Executive Business Manager of *The Ohio State Medical Journal*. Each



received a watch as a gift from the Association and Mr. Moore received a plaque. Mr. Moore addressed the House of Delegates.

### Reference Committees Appointed

The following House of Delegates Reference Committees were appointed by the President:

**Credentials of Delegates**—Robert B. Elliott, Chairman, Hardin County; Marvin McClellan, Hamilton County; Irving A. Nickerson, Licking County; Richard W. Avery, Medina County.

**President's Address**—Luther W. High, Chairman, Holmes County; Richard L. Fulton, Franklin County; Harold Schiro, Hamilton County; John J. Gaughan, Cuyahoga County.

**Tellers and Judges of Election**—Earl R. McLoney, Chairman, Huron County; Christopher A. Colombi, Cuyahoga County; John E. Albers, Hamilton County; John D. Morley, Summit County; Philip H. Taylor, Franklin County; Harry A. Killian, Lake County.

**Resolutions Committee No. 1**—John N. Meagher, Chairman, Franklin County; William V. Trowbridge, Cuyahoga County; W. J. Lewis, Montgomery County; Thomas E. Fox, Warren County; Walter A. Daniel, Seneca County; Roland Gandy, Lucas County; Sanford Press, Jefferson County; Walter B. Devine, Muskingum County; Thomas P. Price, Jr., Gallia County; William Dörner, Summit County; James T. Stephens, Lorain County.

**Resolutions Committee No. 2**—Jasper M. Hedges, Chairman, Pickaway County; Peter A. Overstreet, Lucas County; Frank P. Cleveland, Hamilton County; Jerry L. Hammon, Miami County; Paul E. Lyon, Marion County; Jack Schreiber, Mahoning County; Philip T. Dough-ten, Tuscarawas County; Leland P. Randles, Athens County; Henry A. Crawford, Cuyahoga County; S. Baird Pfahl, Jr., Erie County; Roger P. Daniels, Meigs County.

**Resolutions Committee No. 3**—Clarence L. Huggins, Chairman, Cuyahoga County; George J. Schroer, Shelby County; David A. Barr, Allen County; T. F. Moriarty, Henry County; Keith DeVoe, Jr., Franklin County; Edward E. Grable, Stark County; Carl A. Lincke, Carroll County; Robert A. Ringer, Guernsey County; A. Burton Payne, Lawrence County; Hall S. Wiedemer, Richland County; Robert S. Heidt, Hamilton County.

**Resolutions Committee No. 4**—Frederick P. Osgood, Chairman, Lucas County; Andrew J. Weiss, Hamilton County; Ernest H. Winterhoff, Clark County; James H. Steiner, Logan County; Carl G. Madsen, Jr., Lake County; E. Joel Davis, Stark County; Norman L. Wright, Coshocton County; Richard E. Hartle, Fairfield County; Chester H. Allen, Scioto County; Sol Maggied, Madison County; Charles G. Adams, Lorain County.

### Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations:

**First District**—Charles D. Feuss, Jr., Hamilton County.

**Second District**—Isador Miller, Champaign County.

**Third District**—Robert Oyer, Auglaize County.

**Fourth District**—M. Brodie James, Lucas County.

**Fifth District**—Frederick T. Suppes, Cuyahoga County.

**Sixth District**—William A. White, Jr., Stark County.

**Seventh District**—Elias Freeman, Harrison County.

**Eighth District**—Gregory B. Krivchenia, Washington County.

**Ninth District**—A. Burton Payne, Lawrence County.

**Tenth District**—Michael A. Anthony, Franklin County.

**Eleventh District**—A. Burney Huff, Wayne County.

Dr. Schultz then announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the committee this year would be the delegate from the Eleventh District, Dr. A. Burney Huff, Wayne County.

### President's Address

Mr. Page then introduced President William R. Schultz, Wooster, who delivered his Presidential Address. (Text of the address appears on page 527). After the Address, the House gave Dr. Schultz a standing ovation.

## Introduction of Representatives of other State Societies

Dr. Schultz introduced the following out-of-state presidents: Dr. James H. Gosman, President, Indiana State Medical Association; Dr. Lee C. Hess, President, Kentucky Medical Association; Dr. Worthly W. McKinney, President, West Virginia State Medical Association; Dr. Gerald J. Derus, President, State Medical Society of Wisconsin.

Also introduced at this time were: Mr. James A. Waggener, Executive Secretary, Indiana State Medical Association; Mr. John H. Austin, Canton, President of the Association of County Medical Executives, and Miss Patti Gibbons, SAMA Chapter, University of Cincinnati College of Medicine.

## Introduction of Resolutions

Dr. Schultz then called for the introduction of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to the delegates in advance of the meeting could be introduced by reading of the title only. Fifty-six resolutions plus reports from the Ad Hoc Committee on Health Care Delivery Systems and from the Commission on Medical Education were introduced and were referred to the resolutions committees.

It was moved, seconded and carried that Resolutions 4-73, 5-73, 7-73, 9-73, 12-73, 15-73, 19-73, 21-73, 31-73, 42-73 and 51-73 be referred as a group to Resolutions Committee No. 2 because of their similarity.

## Resolutions Referred to Council

Two resolutions were referred directly to Council, as they were of an ethical nature: Resolution No. 3-73, Ethics of Charging Interest Rates, submitted by the Academy of Medicine of Columbus and Franklin County, and Resolution No. 30-73, Ethical Status of Provider Agreement, submitted by the Ross County Medical Society.

## Withdrawal of Resolution No. 44-73

At the request of the Summit County Medical Society, Resolution No. 44-73, entitled, Sale of Cigarettes in Hospital Confines, was withdrawn.

## Report of the Committee on Emergency Resolutions

"The Committee on Emergency Resolutions, consisting of the chairmen of the four resolutions committees, met this afternoon to consider two

emergency resolutions which were submitted after March 7, 1973, the last date for filing of resolutions in the regular manner.

"The first Emergency Resolution was submitted by the Academy of Medicine of Cleveland and was entitled "Ohio State Public Welfare Department Time Limitation on Medical Prescriptions for Welfare Recipients."

"The vote of the committee on this resolution, with one abstention, was that although the resolution is timely and merits the attention of the House, it does not qualify as a justified Emergency Resolution.

"It was the further opinion of this committee that the Cleveland Academy of Medicine sponsors consider at least two other alternatives of bringing this matter to the attention of the House of Delegates. The first suggested alternative is that of including this matter in other resolutions to come before the House of Delegates that deal with the ODPW. The second alternative being to submit the problem referred to in the resolution to The Council of the Ohio State Medical Association, which is empowered to act on policy matters between the Annual Meetings of the House of Delegates.

"The second Emergency Resolution, presented by The Council of the OSMA, with regard to discrimination against non-resident students, was the result of information released by the Ohio Board of Regents between the January 27-28 and the March 16-18 meetings of The Council, making it impossible for the resolution to be submitted by the deadline, March 7.

"The committee voted that the emergency aspects of the presentation of this resolution are therefore justifiable and it is therefore recommended that it be accepted for consideration by this House of Delegates.

"Mr. President, I move that this report of the Committee on Emergency Resolutions be accepted by the House of Delegates.

"Respectfully submitted: John N. Meagher, Franklin County; Clarence L. Huggins, Cuyahoga County; Frederick P. Osgood, Lucas County, and Jasper M. Hedges, Chairman, Pickaway County."

Dr. Fishman read the text of the resolution:

## RESOLUTION NO. 58-73

### Discrimination Against Non-Resident Students

(By The Council of the Ohio State Medical Association)

WHEREAS, the Ohio Board of Regents has expressed interest in withholding from the medical schools student per capita appropriations of the Ohio General Assembly for all non-resident students attending medical schools in Ohio, and

WHEREAS, more physicians practicing in Ohio received their medical education outside Ohio than in Ohio, and

*(Continued on next page)*

WHEREAS, more Ohio students entered medical school in 1972 outside Ohio than non-Ohio residents entering medical schools in Ohio, and

WHEREAS, such discrimination against non-resident students could cause similar reaction against Ohioans studying medicine outside the state, THEREFORE, BE IT

RESOLVED, that the Ohio State Association hereby expresses grave concern and opposition to any such discriminatory practice, AND BE IT

FURTHER RESOLVED, that such discrimination, if put into effect, would create a medical education "iron curtain" around Ohio at a time when Ohio needs many more, not fewer physicians.

By official action, the report was adopted, and the Emergency Resolution was assigned to Resolutions Committee No. 4.

### House Recessed

The House then recessed until the final session, 3:30 p.m., Wednesday, May 9.

### MINUTES OF THE FINAL SESSION

The final business session of the House of Delegates convened at 3:30 p.m., Wednesday, May 9, at the Sheraton Columbus Hotel.

#### Committee on President's Address

Dr. Schultz then called for the report of the Reference Committee on President's Address (see page 536), which was presented to Dr. Luther W. High, Holmes County, chairman of the committee. The report read as follows:

"Dr. Schultz, members of the House of Delegates, honored guests and friends: The Committee on the President's Address respectfully submits the following report.

"In his inaugural address to this House one year ago, Dr. Schultz proposed a program of 'Up With Medicine.' His address this year was a progress report on that proposal.

"Professional Standards Review Organizations are now the law of the land. There are those among us who would ask that we disregard this law. To do this would be catastrophic and would only lead to complete governmental control of this aspect of the practice of medicine. The Council of the Ohio State Medical Association has considered the value of Medical Advances Institute. PSRO within the framework of MAI will do much to promote the best type of medical care within the state of Ohio. This Committee feels that too often government is concerned primarily with the cost of medical care, relegating quality to a secondary position. It is hoped that any program

instituted under MAI will concern itself primarily with the quality of care administered.

"This Committee believes that the time is long past when we can continue to ignore those of our colleagues who have not kept up with the advances of good medical care. PSRO at the state level can accomplish much, not only in upgrading medical care, but in reeducating those who do not follow the concept of what is considered good diagnosis and treatment. MAI will also indirectly promote continuing medical education, with which we are concerned in this session. This Committee feels that PSRO should be at a state level, acting as an umbrella for local PSRO organizations, with local autonomy, which will insure the optimum result.

"Dr. Schultz points out that the medical profession has been maligned by the politicians, the news media, and many of the government agencies connected with the health problem. He now sees a slight trend in the opposite direction. Government is slowly beginning to see that the problem of good health and proper care of the sick cannot become a political football to be kicked around for political gain; and if the problem is to be resolved, the physician must be consulted.

"This Committee suggests that the government and all agencies look not only to physicians on the staffs of their many agencies, and to those on the staffs of the universities and medical complexes, but also to practicing physicians, be they specialists or family practitioners, who meet the problems every day, and who are knowledgeable in patient care, and can contribute much to the solution of the problems. Since much of the medical care of this nation is administered by solo physicians, both in the urban and rural areas, it seems logical that practicing physicians working in these fields be consulted.

"Your President refers to a book written by Harry Schwartz and recommends that all physicians, politicians and personnel in the health planning field read this book as it represents an extensive study of many of the health care problems we face.

"Dr. Schultz is quite concerned about the physicians who are not members of their local medical society, OSMA and AMA. Too often those who complain the most and say that organized medicine, particularly the state and national organizations, do not represent them, are those who do not participate in the planning and activities of the medical societies.

"Some among us recommend that we form labor unions and that we form new organizations independent of those which have been long established. This does not appeal to the members



of this Committee. In fact, the several splinter organizations which have been formed seem to fragment physicians rather than uniting them into solving the health care problems. If those individuals active in these splinter organizations would devote an equal amount of time to establish organizations such as OSMA, much could be accomplished. We hear from some that the OSMA and AMA are not responsive to its membership. These individuals should make positive suggestions in their field of expertise so that a united front might be obtained in solving the problems of health care. This House is surely a democratic representation of the physicians of Ohio and if it fails to do its work well, the responsibility rests with those physicians who elected their delegates and those, who through non-membership, did not vote for their representatives to this House.

"We all owe much to this profession which has done so much for each of us as individuals, and for which we should be most thankful.

"Your President referred to OMPAC. There was a time when it was felt that physicians need not concern themselves with politics. Dr. Schultz points out that this is no longer true and he urges that every physician in the state of Ohio become a member of OMPAC and AMPAC to insure support for candidates who recognize the problems of health care, and who desire to achieve reasonable and practical solutions to existing problems. During this session medical care foundations and continuing education for physicians is being discussed. It is urgent that each of us becomes knowledgeable about these two issues.

"Your President presents a proposal for a report from each Councilor District. Criticism of Council action too frequently comes from a misunderstanding of the function of The Council, and the district which each Councilor represents. A report by The Council to this House could well clear up many of these misunderstandings.

"In conclusion, Dr. Schultz and your Committee strongly urges that all officers of the representative county medical organizations start an active recruitment program to bring into membership every eligible physician in the state of Ohio.

"This Committee wishes to compliment Dr. Schultz on a job well done: Richard L. Fulton, M.D., Franklin County; Harold Schiro, M.D., Hamilton County; John J. Gaughan, M.D., Cuyahoga County; and Luther W. High, M.D., Holmes County, Chairman."

On a motion made and seconded, the House of Delegates, by official action approved the report of the Reference Committee on President's Address. One negative vote was recorded.

## Report of Credentials Committee

Dr. Robert B. Elliott, Hardin County, Chairman of the Committee on Credentials, reported 160 delegates were seated and eligible to vote.

## Election of President-Elect

Dr. Schultz called for nominations for the office of President-Elect. Dr. Richard L. Fulton, Franklin County, placed in nomination Dr. James L. Henry, Grove City, Franklin County, Secretary-Treasurer of the Association. The nomination was duly seconded by Dr. Maurice F. Lieber, Stark County, Sixth District Councilor. Dr. Harve Clodfelter, Columbus, a Past President was granted the privilege of the floor and addressed the House.

There were no other nominations and the House voted to elect Dr. Henry by acclamation.

## Report of Nominating Committee

Dr. A. Burney Huff, Delegate, Wayne County, Chairman, Committee on Nominations, presented the report of the Nominating Committee as follows:

### Secretary-Treasurer

For Secretary-Treasurer, the committee placed in nomination the following: Dr. Thomas E. Fox, Warren County; Dr. Sol Maggied, Madison County, and Dr. William M. Wells, Licking County and Eighth District Councilor. Dr. Wells was declared elected on the second ballot.

### Councilors

#### Second District

As Councilor of the Second District to succeed himself, the committee placed in nomination Dr. James G. Tye, of Dayton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Tye was declared reelected Councilor of the Second District for a term of two years, 1973-1974 and 1974-1975.

#### Fourth District

As Councilor of the Fourth District to succeed himself, the committee placed in nomination Dr. George N. Bates, of Toledo. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Bates was declared reelected Councilor of the Fourth District for a term of two years, 1973-1974 and 1974-1975.

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## Sixth District

As Councilor of the Sixth District to succeed himself, the committee placed in nomination Dr. Maurice F. Lieber, of Canton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Lieber was declared reelected Councilor of the Sixth District for a term of two years, 1973-1974 and 1974-1975.

## Eighth District

As Councilor of the Eighth District to succeed Dr. William M. Wells, Newark, the committee placed in nomination Dr. Richard E. Hartle, Lancaster. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Hartle was elected Councilor of the Eighth District for a term of two years, 1973-1974 and 1974-1975.

## Tenth District

As Councilor of the Tenth District to succeed himself, the committee placed in nomination Dr. James C. McLarnan, of Mt. Vernon. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. McLarnan was declared reelected Councilor of the Tenth District for a term of two years, 1973-1974 and 1974-1975.

## AMA Delegates

Dr. Huff then presented the nominees for the office of delegate to the American Medical Association for a term of two years beginning January 1, 1974: Drs. Oscar W. Clarke, Gallipolis; Henry A. Crawford, Cleveland; Harry K. Hines, Cincinnati; P. John Robeck, Cleveland; Jack Schreiber, Canfield, and W. J. Lewis, Dayton. The nominations were duly seconded and there were no further nominations from the floor. A secret ballot was taken and the following were elected delegates to the American Medical Association for a term of two years, beginning January 1, 1974: Drs. Clarke, Crawford, Hines, Robeck and Lewis.

## AMA Alternate Delegates

For alternate delegates to the American Medical Association for a term of two years beginning January 1, 1974, the Nominating Committee placed in nomination the names of Drs. George N. Bates, Toledo; Richard L. Fulton, Columbus; Jerry L. Hammon, West Milton; Jack

Schreiber, Canfield; Robert S. Heidt, Cincinnati, and William R. Schultz, Wooster. The nominations were duly seconded and there were no further nominations from the floor. A secret ballot was taken and the following were elected alternate delegates to the American Medical Association for a term of two years, beginning January 1, 1974: Drs. Bates, Fulton, Hammon, Schreiber and Schultz.

The following were nominated for an unexpired term, ending December 31, 1974: Dr. Bernard L. Huffman, Jr., Toledo and Dr. Robert S. Heidt, Cincinnati. A secret ballot was taken and Dr. Huffman was declared alternate delegate to the American Medical Association for a one-year term.

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## Report of Resolutions Committee No. 1

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Dr. John N. Meagher, Franklin County, reported for Resolutions Committee No. 1, of which he was chairman. The report read as follows:

"Your Resolutions Committee No. 1 met in open hearing and heard testimony at length regarding PSRO and MAI. We are fully cognizant that PSRO and MAI are not interchangeable terms, nor are they in any sense synonymous. PSRO is but a single facet of the several responsibilities of MAI. That responsibility, in the area of PSRO in so far as MAI is concerned, was clearly set forth in the actions of this House of Delegates in 1972.

"We have heard arguments pro and con from our many respected delegates and colleagues. We are aware that this issue is perhaps one of the most emotional issues that American Medicine has had to confront in recent times. We sympathize and agree with those who feel that this law, Public Law 92-603, represents a further, unwarranted intrusion by the federal government into the private practice of medicine. We sincerely wish that the law did not exist! Nonetheless, we were charged as a committee with coming to grips with the issue and it made no matter in which direction we turned, we were always faced with a law that exists; one with which, we, as physicians and American citizens must comply!

"In attempting to seek something of good, if there be any good in this law, it was the committee's unanimous conviction, that we would be remiss if we did not take full advantage of the opportunity offered us in the law to control our own destiny in so far as future administration of this law will permit us to do so. We are unified, in committee, in the solid belief that professional



standards review, in medicine, can be done properly only by practicing physicians.

"Therefore, the committee offers Substitute Resolution 29-73 in lieu of Resolutions 14-73, 26-73, 29-73, 32-73, 45-73, 48-73, 54-73 and 55-73."

#### SUBSTITUTE RESOLUTION 29-73 MAI-PSRO

WHEREAS, In May 1972 the OSMA House of Delegates endorsed the concept and development of a program of Professional Standards Review, and

WHEREAS, The 1972 OSMA House of Delegates recommended to Medical Advances Institute that it investigate and develop methods and mechanisms for a Professional Standards Review Organization (PSRO) for the State of Ohio, and

WHEREAS, The Federal Congress has passed Public Law 92-603 requiring the implementation of PSRO by 1974, and

WHEREAS, Practicing physicians from throughout the State of Ohio have developed quality assurance criteria for disease entities, and

WHEREAS, Medical Advances Institute has established an organization that meets the requirements of present federal laws for professional standards review in the State of Ohio, and has developed quality assurance criteria that are computer acceptable, THEREFORE, BE IT

RESOLVED, That the OSMA House of Delegates recommend to Medical Advances Institute that it accept financial aid to develop continuing programs of PSRO, and BE IT FURTHER

RESOLVED, That Medical Advances Institute be encouraged to seek a provisional contractual agreement with the Secretary of Health, Education and Welfare to act as the PSRO for the area of the State of Ohio, in accordance with Public Law 92-603, AND BE IT FURTHER

RESOLVED, THAT, IF ANY RULES OR REGULATIONS PROMULGATED BY THE SECRETARY OF HEW CONSTITUTE A VIOLATION OF MEDICAL ETHICS OR OSMA POLICY AND/OR CAUSE A DETERIORATION OF THE QUALITY OF CARE RENDERED TO PATIENTS, THEN OSMA COUNCIL SHALL IMMEDIATELY RECOMMEND TO MAI THAT IT NOTIFY THE SECRETARY OF HEW THAT ANY PROVISIONAL AGREEMENT BE TERMINATED.

"And, Mr. President, I move its adoption."

By official action, Substitute Resolution No. 29-73 was amended by the House and was adopted as amended. Additions by the House are indicated by all capital letters.

#### OFMC

"We next heard testimony regarding the report of the Ad Hoc Committee on Health Care Delivery Systems on the proposal of an Ohio Foundation for Medical Care. This, again, provoked lengthy discussion both pro and con, and your committee gave careful attention to all of the opinions expressed.

"As in many problems that have been presented to previous sessions of this House of Delegates, your committee felt that we should continue the established flexibility of the Ohio State Medical Association in its endorsement and acceptance of a plurality of systems for the delivery of medical care in the State of Ohio.

#### REPORT OF THE AD HOC COMMITTEE ON HEALTH CARE DELIVERY SYSTEMS

"The committee considered the Ad Hoc Committee on Health Care Delivery Systems' Report, entitled 'Proposal for the Establishment of the Ohio Foundation for Medical Care,' as embodied in the 16 page document submitted to the House of Delegates, and we recommend its acceptance and its implementation at the discretion of the Council of the Ohio State Medical Association, AND THAT OSMA DEVELOP OFMC TO ASSIST LOCAL AND REGIONAL MEDICAL ASSOCIATIONS IN THE DEVELOPMENT AND IMPLEMENTATION OF LOCAL AND REGIONAL FOUNDATIONS FOR MEDICAL CARE AND LOCAL CONTROL OF POLICY."

By official action, the "Report of the Ad Hoc Committee on Health Care Delivery Systems," as amended, was approved by the House of Delegates. The House amendment is indicated by capital letters and includes the comma in place of the period after the word "Association."

"I wish to express my personal appreciation to the outstanding members of my committee for their astute awareness of the many facets with which we were confronted. Their knowledge, dedication, and plain hard work made the development of the above report possible. It was a pleasure, personally, to work with them.

"I wish to express my thanks for the helpful services of the legal counsel of the Ohio State Medical Association and to the executive staff and secretarial staff for their invaluable help.

"This report is respectfully submitted by the following members of Resolutions Committee No. 1: William V. Trowbridge, Cuyahoga County; W. J. Lewis, Montgomery County; Thomas E. Fox, Warren County; Walter A. Daniel, Seneca County; Roland Gandy, Lucas County; Sanford Press, Jefferson County; Walter B. Devine, Muskingum County; Thomas P. Price, Jr., Gallia County; William Dorner, Summit County; James T. Stephens, Lorain County; John N. Meagher, Chairman, Franklin County."

By official action, the report of Resolutions Committee No. 1 as a whole, as amended, was approved by the House of Delegates.

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## **Report of Resolutions Committee No. 2**

Dr. Jasper M. Hedges, Pickaway County, reported for Resolutions Committee No. 2, of which he was chairman. The report read as follows:

"Resolutions Committee No. 2 held hearings on twenty resolutions, including eleven resolutions on Family Practice.

"The Committee's open session gave full and adequate opportunity for consideration of the resolutions by all members of the House of Delegates and by the members of the Ohio State Medical Association who appeared before it.

"The open session was conducted during the morning and the executive session was held in the afternoon of May 7, 1973.

"The first resolutions considered by the Resolutions Committee were the resolutions concerning Departments of Family Practice. These resolutions were 4-73, 5-73, 7-73, 9-73, 12-73, 15-73, 19-73, 21-73, 31-73, 42-73, and 51-73.

"In trying to accurately evaluate these resolutions it became evident that there had been new legislation introduced in the Ohio legislature subsequent to the drafting of the original resolutions. Because of this newly introduced legislation and after consultation with representatives of the Ohio Academy of Family Physicians a substitute resolution (4-73) is hereby presented in lieu of the aforementioned resolutions:"

### **SUBSTITUTE RESOLUTION NO. 4-73**

#### **Departments of Family Practice**

WHEREAS, The number of family physicians is declining, thus limiting access to medical care for the people of Ohio, and

WHEREAS, Legislation has been introduced in the Ohio legislature to provide funds for the development and operation of departments of family medicine in each state-supported medical college in Ohio: THEREFORE, BE IT

RESOLVED, That The Ohio State Medical Association support legislation this year in the Ohio General Assembly which will expressly provide funds for the development and operation of a Department of Family Practice in each medical college in Ohio.

"The Committee unanimously recommends that substitute resolution 4-73 be adopted and, Mr. President, I so move."

By official action, Substitute Resolution No. 4-73 was adopted.

### **RESOLUTION NO. 10-73**

#### **To Authorize Contraceptive and Pregnancy Advice and Treatment for Minors without Parental Consent**

"The next resolution considered by our Committee was Resolution No. 10-73 entitled 'To

Authorize Contraceptive and Pregnancy Advice and Treatment for Minors without Parental Consent.'

"The Committee heard a great deal of very informative testimony concerning this resolution. It was the consensus of the Committee that this resolution should be amended as follows:"

### **AMENDED RESOLUTION NO. 10-73**

WHEREAS, Venereal Disease is now widespread in the younger age group,

WHEREAS, Teenage pregnancies are increasing at an alarming rate, and

WHEREAS, There is an increasing reservoir of adolescents, early teenagers and minors who are not being reached, and

WHEREAS, Current rules, regulations and laws permit diagnosis and treatment of venereal disease and drug abuse but do not permit advice for contraception, and

WHEREAS, Many minors can be reached by a proper physician-patient relationship based on mutual trust, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association cooperate with the Ohio legislature by requesting the introduction of legislation permitting Ohio physicians to treat minors without parental consent in the following respects:

1. To counsel about, as well as diagnose and treat Venereal Disease.

2. To counsel about and prescribe methods for contraception.

3. To medically manage pregnancy, EXCLUDING ABORTION.

"Mr. President our Committee unanimously recommends that Resolution No. 10, as amended, be adopted and, Mr. President, I so move."

By official action Resolution No. 10-73 was amended by the House as indicated by the capital letters and was adopted.

### **RESOLUTION NO. 23-73**

#### **Private Practice**

"The next resolution to come before Resolutions Committee No. 2 was Resolution No. 23-73 entitled 'Private Practice' submitted by the Lake County Medical Society.

"At the open session of our Committee there were no discussants for or against this resolution and in the executive session it was felt that certain sections of the resolution were somewhat ambiguous and in consultation with its author, the resolution was amended as follows:"

### **AMENDED RESOLUTION NO. 23-73**

WHEREAS, The House of Delegates of the Ohio State Medical Association has in recent years repeatedly endorsed the concept of medical practice on a fee-for-service basis, stating that the patient has as direct

a financial responsibility to the physician as the physician has a medical responsibility to the patient, THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association again reaffirms its policy of encouragement to those members wishing to practice medicine on a fee-for-service basis to "bill your patient!"

"The Committee unanimously recommends the adoption of Resolution No. 23-73, as amended and, Mr. President, I so move."

By official action **Amended Resolution No. 23-73 was adopted.**

#### RESOLUTION NO. 41-73

"The Committee next considered Resolution No. 41-73 entitled 'Smoking Areas in some Ohio Schools.'

"The Committee felt that the intent of this resolution was excellent and recommends that it be adopted as introduced and, Mr. President, I so move."

#### RESOLUTION No. 41-73

##### Smoking Areas in some Ohio Schools

WHEREAS, The medical profession is on record as considering smoking hazardous to health; and

WHEREAS, The American Medical Association and National Education Association through their Joint Committee on Health Problems in Education — and the Ohio State Medical Association through its Committee on School Health — are advocating comprehensive health education programs which include units on the hazards of smoking for Ohio pupils, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association urge the Ohio Department of Education, Ohio School Boards Association, the Ohio Education Association and the Division of Health Education, Ohio Department of Health, to exert their influence to eliminate a current "double standard" in some Ohio schools by discouraging the development of smoking areas within school buildings for faculty and students at the expense of taxpayers, and BE IT FURTHER

RESOLVED, That copies of this resolution be forwarded to the aforementioned organizations.

By official action **Resolution No. 41-73 was adopted.**

#### RESOLUTION NO. 49-73

##### Maternity Hospital Regulations

"The Committee next considered Resolution No. 49-73 entitled 'Maternity Hospital Regulations' submitted by the Stark County Medical Society.

"All the participants in the open session of this Committee felt the resolution was timely and pertinent. The executive session of the Committee concurred and recommended that it be adopted without change and, Mr. President, I so move."

#### RESOLUTION No. 49-73

WHEREAS, The Division of Child Hygiene of the Department of Health of the State of Ohio periodically, by law, inspects the maternity divisions of hospitals in the State of Ohio, and

WHEREAS, The inspectors (consultants) assigned by this Division have again enlarged upon the areas in which they claim authority to inspect, and

WHEREAS, Many of the recommendations of the inspectors are written in a manner implying that implementation of the recommendations is required for continuation of the maternity license . . . when, in fact, it is not, and

WHEREAS, The House of Delegates of the Ohio State Medical Association expressed its disapproval of these practices in "Amended Resolution on Maternity Hospital Inspections," (1960) THEREFORE, BE IT

RESOLVED, That inspectors reports which claim violation(s) of the Maternity Hospital Regulations of the Sanitary Code of the State of Ohio shall list by number which section(s) of the Regulations are being violated and, BE IT FURTHER

RESOLVED, That recommendations not specific to the Maternity Hospital Regulations be clearly noted as such, with the further written statement that failure to implement such recommendations shall in no way constitute a threat of revocation of a maternity hospital license.

By official action, **Resolution No. 49-73 was adopted.**

#### RESOLUTION NO. 50-73

##### Waiver of OSMa Dues at Age 70

"The Committee next dealt with a perennial favorite, Resolution No. 50-73, submitted by the Academy of Medicine of Toledo and Lucas County and entitled 'Waiver of OSMa Dues at Age 70.'

"The Committee was the recipient of no discussion with regard to this resolution. It did note that previous similar resolutions concerning waiver of dues on the basis of age have been introduced in 1950, 1951, 1952, 1958, 1964, 1965, and 1972 and that none of these had been adopted.

"It again, as in the past, was the unanimous opinion of the Committee that this resolution should be not adopted and, Mr. President, I so move."

By official action, **Resolution No. 50-73 was defeated.**

#### RESOLUTION NO. 53-73

##### Constitutional Amendment to Protect the Right to Life

"The next resolution considered by our Committee was Resolution No. 53-73, entitled 'Constitutional Amendment to Protect the Right to Life.'

"The Committee heard a great deal of testi-



mony from the various members of the Ohio State Medical Association who appeared before it.

"It should be sufficient to note, that there is wide divergence of thinking on this most sensitive and delicate question. We need not resolve the difficult question of when life begins when those trained in the respected disciplines of medicine, philosophy and theology are unable to arrive at any consensus. This Committee, at this point in the development of man's knowledge, is not in a position to speculate as to the answer and on this basis it was the unanimous opinion of our Committee that Resolution No. 53-73, be not adopted and, Mr. President, I so move."

By official action, Resolution No. 53-73 was defeated.

#### RESOLUTION NOS. 13-73, 40-73 AND 52-73

##### Abortion

"The final resolutions considered by our Committee were numbers 13-73, 40-73, and 52-73.

"These resolutions all deal with the highly controversial subject of abortion.

"The Committee was in receipt of a great deal of intelligent, pertinent and informative material presented to it by the participants in the open session of the Committee.

"The Committee was particularly grateful to Doctors Leicht, Sanders and Kilroy of the Cleveland Academy of Medicine and was also deeply grateful to Dr. John Cashman, Ohio Director of Health, as well as, to Dr. Anthony Ruppertsberg, Chairman of the Committee on Maternal Health of the Ohio State Medical Association.

"After much deliberation, it was felt that this particular problem involved many technical as well as moral issues which could not all be resolved. It was the judgment of the Committee, however, that these three resolutions could be best presented to the House of Delegates in the form of a single substitute resolution hereafter called substitute resolution No. 13-73 and entitled 'Abortion as a Medical Procedure.'"

#### SUBSTITUTE RESOLUTION NO. 13-73

##### Abortion as a Medical Procedure

WHEREAS, Recent U.S. Supreme Court decisions have effectively struck down all legal restrictions regarding the performance of abortions in the state of Ohio and,

WHEREAS, The entire responsibility for the procedure rests with the individual physician in the exercise of his medical judgment and,

WHEREAS, The Committee on Maternal Health, after much study and deliberation, has recently issued a statement of policy on abortion and,

WHEREAS, This statement of policy seems to embody the guidelines that would best serve the members of

the Ohio State Medical Association in regard to this particular subject in light of the recent Supreme Court decisions, THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association adopt as its policy the statement on abortion issued by the Ohio State Medical Association's Committee on Maternal Health, WITH THE EXCEPTION THAT ABORTION UPON REQUEST, LIKE ANY OTHER MEDICAL PROCEDURE, SHOULD BE PERFORMED ONLY IN THE MATERNAL PATIENT'S BEST INTERESTS, AND THE STANDARDS OF SOUND CLINICAL JUDGMENT, WHICH TOGETHER WITH INFORMED MATERNAL PATIENT CONSENT, SHOULD BE DETERMINATIVE ACCORDING TO THE MERITS OF EACH INDIVIDUAL CASE.

"A copy of this statement on abortion issued by the Ohio State Medical Association's Committee on Maternal Health previously referred to is as follows:

"This Statement is based on a Statement issued by the American College of Obstetricians and Gynecologists, issued on February 10, 1973 and amended by deletion and insertion by the OSMA Maternal Health Committee. This statement involves terminology that has been approved by the American Medical Association, the American College of Obstetricians and Gynecologists and the American Pediatric Association."

#### STATEMENT ON ABORTION OF OSMA COMMITTEE ON MATERNAL HEALTH

In view of the recent decision of the United States Supreme Court on abortion the following statement is issued by the Ohio State Medical Association's Committee on Maternal Health.

Abortion shall mean an operation to intentionally terminate a pregnancy with a live or stillborn fetus weighing 500 gms. or less, or under 20 completed weeks of gestation. For its performance, adequate facilities, equipment and personnel are required to assure the highest standards of patient care.

First trimester abortions (up to 12 weeks since conception) should be performed in a hospital or in a facility that offers the basic safeguards provided by hospital admission and has immediate hospital back-up. Such a facility should be accredited by the Joint Commission on Accreditation of Hospitals or licensed by the State of Ohio.

Abortions beyond the first trimester should be performed in a hospital.

Facilities for the performance of first trimester abortions should include appropriate surgical, anesthetic and resuscitation equipment. In addition, the following should be provided:

1. Verification of the diagnosis and duration of pregnancy.
2. Pre-operative instructions and counselling.
3. Recorded pre-operative history and physical examination, particularly directed to identification of pre-existing or concurrent illnesses or drug sensitivities that may have a bearing on the operative procedures or the anesthesia.
4. Laboratory procedures as usually required for a hospital admission, including blood type and Rh factor.
5. Prevention of Rh sensitization.
6. A receiving facility where the patient may be



prepared and receive necessary pre-operative medication and observation prior to the procedure.

7. A recovery facility in which the patient can be observed until she has sufficiently recovered from the procedure and the anesthesia and can be safely discharged by the physician.

8. Post-operative instructions and arrangements for follow-up including family planning advice.

9. Adequate permanent records.

It is recognized that abortion may be performed at a patient's request or upon a physician's recommendation. No physician should be required to perform, nor should any patient be forced to accept an abortion.

The usual informed consent, including operative permit, should be obtained. The same indications for consultation should apply to abortions as to other medical-surgical procedures.

Abortion should be performed only by licensed physicians who are qualified to identify and manage those complications that may arise from the procedure.

"The Committee therefore recommends that Substitute Resolution No. 13-73, be adopted by this House of Delegates and, Mr. President, I so move."

By official action Substitute Resolution No. 13-73, was amended by the House as indicated by capital letters and was adopted as amended.

"Mr. President, I move the adoption of this (amended) report of Resolutions Committee No. 2 as a whole.

"I wish to express my sincere thanks to all of the members of my Committee for their thoughtful consideration of all resolutions presented to it. I wish also to thank our legal counsel, Mr. James Pohlman, for his support on reviewing this report. In addition my appreciation is extended to all of those who presented testimony and lending their insight and wisdom to the resolutions under discussion and my special thanks to the executive and secretarial staff of the Ohio State Medical Association.

"The members of my Committee who gave enthusiastically of their time and expertise and who respectfully submit this report are: Peter A. Overstreet, Lucas County; Frank P. Cleveland, Hamilton County; Jerry L. Hammon, Miami County; Paul E. Lyon, Marion County; Jack Schreiber, Mahoning County; Philip T. Dough-ten, Tuscarawas County; Roger P. Daniels, Meigs County; Leland P. Randles, Athens County; Henry A. Crawford, Cuyahoga County; S. Baird Pfahl, Jr., Erie County; Jasper M. Hedges, Chair-man, Pickaway County."

By official action the report of Resolutions Committee No. 2 as a whole, as amended, was approved by the House of Delegates.

## **Report of Resolutions Committee No. 3**

In the absence of Dr. Clarence L. Huggins, Chairman of Resolutions Committee No. 3, Dr. Robert S. Heidt, a member of the committee reported for Resolutions Committee No. 3.

"Resolutions Committee No. 3 had for its consideration the following resolutions: Resolution Nos. 6, 11, 16, 18, 22, 25, 27, 33, 34, 35, 36, 39, and 46."

### **RESOLUTION NOS. 6-73 AND 16-73**

"Resolution No. 6-73 entitled Provider Agree-ment (by the Delaware County Medical Society) and No. 16-73 entitled Ohio Department of Public Welfare Regulations (by the Ross County Medical Society) had a commonality of purpose and a remarkable similarity of content. For that reason they were combined to form a substitute resolu-tion."

### **SUBSTITUTE RESOLUTION NO. 6-73**

#### **Ohio Department of Public Welfare Provider Agreement**

WHEREAS, The regulations issued by the Ohio Department of Public Welfare (ODPW), on September 1, 1972 provide for the inspection of personal case histories of patients by third party lay inspectors; this being contrary to the ethics of medicine, which require the maintenance of confidentiality, the destruction of which will critically impair the physician-patient relationship, and impede effective medical treatment, and

WHEREAS, This agreement requires that physicians must accept payment for their services on a fee profile developed by the ODPW, this profile being unknown, and their being no recourse to the ODPW decisions on payment, and

WHEREAS, This agreement is a blatant coercion of the medical profession by an agency of the government, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association go on record as ~~being opposed to the provider agree-ment, and that its member physicians be encouraged to refuse to enter into any such contract with the Welfare Department, and to revoke any contract already in force.~~ CONTINUING OUR OPPOS-ITION TO THE PROVIDER AGREEMENT, and BE IT FURTHER

RESOLVED, THAT THE OHIO STATE MEDICAL ASSOCIATION, THROUGH A RESOLUTION TO THE AMA, AS WELL AS THROUGH ALL OTHER POSSIBLE AVENUES FOR RELIEF, AT-TEMPT TO ALLOW THE PHYSICIANS OF THE STATE OF OHIO TO CONTINUE TREATMENT OF THE POOR, WITHOUT THE NECESSITY OF SIGNING SUCH AN INSULTING CON-TRACT AS THAT WHICH IS NOW REQUIRED BY THE OHIO DEPARTMENT OF WELFARE, AND BE IT FURTHER

RESOLVED, That the Ohio State Medical Association recommend that its members continue to treat patients

as always, in the highest medical tradition without discrimination referable to race or ability to pay, AND TO BILL THE OHIO DEPARTMENT OF PUBLIC WELFARE FOR SERVICES TO WELFARE PATIENTS, FOR INDIVIDUAL SERVICES RENDERED, CONSISTENT WITH THE "FAIR FEE CONCEPT" ALREADY ACCEPTED BY THE OSMA FOR ALL PATIENTS.

"The Committee recommends its acceptance and I so move."

By official action, the House voted to amend Substitute Resolution No. 6-73 as indicated by the strike-out deletions, and by the additions set forth in capital letters, then adopted it.

#### RESOLUTION NO. 11-73

##### Emergency Medical Care

"Resolution No. 11-73 Emergency Medical Care (by the Academy of Medicine of Cleveland). There were minor amendments made to the resolution by its author properly designating committees improperly designated in the original submission of the resolution and a deletion of the suggested telephone number due to a nonconformity of the various telephone companies operating in the State of Ohio."

#### AMENDED RESOLUTION NO. 11-73

WHEREAS, Each year one in four Americans will sustain a serious accident with 400,000 people disabled including 50,000 paraplegics, and 110,000 deaths, at a cost of 20 billion dollars, and

The traffic rate has shown a progressive rise each year with traffic deaths alone rising from 39,000 in 1961 to 57,000 in 1971, and

There are 625,000 persons who die from heart disease each year, 70% of whom expire before reaching a hospital, and

WHEREAS, The majority of ambulance service in the State of Ohio is primarily transportation service with few attendants having completed advanced medical technician's training, and

WHEREAS, It has been shown by the military and by those communities already using advanced emergency medical care technology, that improved emergency medical care (before reaching a medical facility) will significantly reduce death, disability and ultimately cost, and

WHEREAS, The AMA, American College of Surgeons, American Heart Association, American Trauma Society, National Academy of Science, Department of Transportation, and others have all recommended the development of improved emergency medical care techniques with all possible speed, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association through its Emergency and Disaster Medical Care Committee, and in cooperation with the Ohio Health Service Coordinating Council of the Department of Health and other agencies involved in improving emergency health care, stimulate and encourage the development of improved emergency medical care and transportation in communities throughout the state with emphasis on the following: (1) an integrated communication system; (2) establishment of a uni-

versal toll free medical emergency phone number; (3) categorization of all emergency departments throughout the state by the local county medical societies following guidelines established by the OSMA; (4) standardization of ambulance technicians (EMT) training, examination, and certification as well as ambulance and MICU forms; (5) encouragement of insurance companies to develop broad plans for payment of ambulance and emergency services; (6) development of plans for education of the public regarding their entry and their role in emergency medical care.

"The Committee recommends acceptance of this amended resolution and I so move."

By official action Amended Resolution No. 11-73 was adopted.

#### RESOLUTION NOS. 18-73, 22-73 AND 34-73

"The next resolution for consideration was No. 18-73 Discrimination Against Physicians (by the Ross County Medical Society). This was discussed simultaneously with Resolution No. 22-73 Price Control (by the Council of the Lake County Medical Society) and Resolution No. 34-73 Government Controls (by the Huron County Medical Society), again because of their commonality of purpose. Resolutions No. 18-73 and 22-73 requested that 'class action' type legal action be taken. It was pointed out to the Committee that in order for a 'class action' suit to be brought by an aggrieved party that said party must show (1) that he has sustained injury as a result of the matter under consideration, and (2) must have exhausted all of the means of administrative relief. The Ohio State Medical Association could not show that it, as an entity, had sustained injury. It was suggested that any member of the organization who had been injured, and felt so disposed, might initiate a suit such as that suggested in Resolutions No. 18 and 22, and that the full weight of the OSMA and the AMA would be brought to bear on his behalf. Having disposed of the legal facet of Resolutions 18, 22, and 34, we submit the following substitute resolution.

#### AMENDED SUBSTITUTE RESOLUTION NO. 18-73

##### Discrimination Against Physicians by Phase III

WHEREAS, The physicians of this nation in cooperation with the spirit of "Phase II" demonstrated quantitatively by the minimal degree to which fees increased, even below the federal guidelines, a willingness of conformity and cooperation unmatched by any other significant segment of the economy, and

WHEREAS, Those rendering medical and health services have been almost singularly and discriminatorily restricted to price increases of 2.5% yearly, continued from Phase II to Phase III, as opposed to all other services and industries, and

WHEREAS, This: (1) is in violation of the intent of the United States Constitution, (2) represses and suppresses individual initiative, (3) is very inimical



to the concept of a free market economy and limited government, (4) violates the most basic fundamental God given and constitutionally guaranteed "right to contract" between two parties, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association undertake all necessary steps, including distribution to members of Congress, to have the discriminatory, arbitrary, illogical and capricious decisions of the Pay Board set aside. AND, BE IT FURTHER

RESOLVED, THAT THE OHIO STATE MEDICAL ASSOCIATION CONSIDER SUPPORT IN APPROPRIATE LEGAL MANNER THE EFFORTS OF O.S.M.A. MEMBERS SEEKING LEGAL REDRESS FOR INJURIES DUE TO THE DISCRIMINATORY REGULATIONS OF THE PAY BOARD AND THAT THE O.S.M.A. INSTRUCT ITS DELEGATES TO THE A.M.A. TO INTRODUCE A KINDRED RESOLUTION TO THAT BODY. AND, BE IT FURTHER

RESOLVED, That the House of Delegates of the Ohio State Medical Association send a copy of this Resolution to every state medical association throughout the country, hoping, thereby, that they might follow a similar procedure.

"The Committee recommends the acceptance of this substitute resolution and I so move."

By official action, the House voted to amend Substitute Resolution No. 18-73 as indicated by the additions set forth in capital letters, then adopted it.

#### RESOLUTION NOS. 25-73 AND 39-73

"The Committee next considered Resolution No. 25-73, Confidentiality (by the Council of the Lake County Medical Society) simultaneously with Resolution No. 39-73 Confidentiality of Medical Records Protection Thereof (by the Huron Medical Society). These two resolutions presented the greatest challenge to Resolutions Committee No. 3 in that three forces, not necessarily competitive one with the other, sought to maintain that which is considered essential to the preservation of the doctor-patient relationship and the financial underwriting of the services attendant thereto. Namely: (1) the right of the patient to disclose freely to his doctor any and all aspects of his life without that information falling into alien hands, (2) the right of the doctor to imprint on the chart any and all information concerning the patient without fear of alien intrusion, and (3) the right of third parties to perform their fiduciary responsibility for their boards of trustees, stockholders, etc., to justify each expenditure under their contractual obligations. The following is a substitute resolution attempting to reconcile those differences."

#### AMENDED SUBSTITUTE RESOLUTION NO. 25-73

##### Preservation of the Confidentiality of Medical Records

WHEREAS, The progressive invasion of the confidentiality of medical records has had a demonstrable

effect of deterioration on the normal doctor-patient relationship, and

WHEREAS, The full benefits of modern medical technology demands that the patient make full and free disclosure, and

WHEREAS, The likelihood of full and free disclosure on the part of the patient depends upon his assurance that said knowledge will be used only for his receiving the full benefits of medical technology, and

WHEREAS, The doctor in the application of modern medical technology for the benefit of the patient requires that his actions not be used to breach one of the most sacred trusts known to man, namely "the doctor-patient relationship," and

WHEREAS, A certain amount of medical information referable to services rendered to enrollees in third party programs underwriting medical services is necessary for the responsible administration of said programs, BE IT THEREFORE

RESOLVED, That the Ohio State Medical Association in conjunction with the JCAH, the necessary state insurance regulatory bodies and appropriate federal regulatory insurance bodies formulate the format for a standardized "Face Sheet" for all hospital charts which will incorporate all of the information necessary for third parties to carry out their contractual obligations in a responsible manner, and BE IT FURTHER

RESOLVED, That should IT BECOME NECESSARY THAT more "in-depth information" be required, at that time, a second, and properly designated, "authorization for the release of information" form be obtained; and that a necessary requisite to obtain this form be that the patient is fully informed referable to the nature of this extraordinary step and that the signatures of both the patient and the doctor be required on said form, and BE IT FURTHER

RESOLVED, That the OSMA, through the appropriate mechanism, have introduced in the state legislature the necessary enabling legislation to validate these actions.

"The Committee recommends acceptance of this resolution and I so move."

By official action Substitute Resolution No. 25-73 was amended as indicated by capital letters and was adopted.

#### RESOLUTION NO. 27-73

##### Welfare

"The next resolution for consideration was Resolution No. 27-73 Welfare (by the Council of the Lake County Medical Society). The resolution requested that the OSMA add its voice to encourage censure by the Governor of the State of Ohio of the Ohio Department of Public Welfare. Extensive material and testimony was produced to show that a persistent high shrill voice on the part of the OSMA in this direction had been evident for a considerable period of time. It was pointed out that the representatives of the OSMA had shown concern but that the House of Delegates itself had not gone on record in this regard. To



perform this function Amended Resolution No. 27-73 was amended as follows:"

#### AMENDED RESOLUTION NO. 27-73

WHEREAS, The federal government and the state government have undertaken the financial responsibility of the health care of the poor, and

WHEREAS, The state legislature has not adequately funded the program to the extent necessary to carry out the promises made, and

WHEREAS, The members of the Ohio State Medical Association in providing the services for which the state has not met its financial responsibility to underwrite have themselves, by default, been required to be the underwriters, BE IT THEREFORE

RESOLVED, That the House of Delegates of the Ohio State Medical Association concurs in the action of The Council and the appropriate committees of the OSMA in pointing out the deficiencies in the state administered program, and lends its full support to all responsible actions in this direction.

"The Committee recommends acceptance of this amended resolution and I so move."

By official action Amended Resolution No. 27-73 was adopted.

#### RESOLUTION NOS. 33-73 AND 35-73

"The Committee next considered Resolution No. 33-73, Deceased Medicare Beneficiaries' Bills to be Paid in Usual and Customary Fashion (by the Huron County Medical Society) and because of its close relationship with Resolution No. 35-73 Medicare Should Honor 'Itemized' Bill of Deceased (by the Huron County Medical Society) chose to combine the two resolutions and offers the following substitute resolution."

#### SUBSTITUTE RESOLUTION NO. 33-73

##### Deceased Medicare Beneficiaries' Bill

WHEREAS, The Social Security Administration reimburses Medicare beneficiaries upon presentation of an itemized bill only, and

WHEREAS, The Social Security Administration through its intermediaries, request that when the beneficiary is deceased the bill submitted must be paid and receipted (rather than itemized only) before payment is made to the estate and/or the doctor, and

WHEREAS, If the beneficiary is deceased and there is no estate or relative the Social Security Administration requires that the doctor either accept the assignment or can receive no payment whatever, and

WHEREAS, This is an unnecessary imposition on both the relatives of the deceased and the physician, and THEREFORE BE IT

RESOLVED, That the Social Security Administration be apprised through the appropriate channels of the inequity of treatment between living and dead beneficiaries, and BE IT FURTHER

RESOLVED, That the Social Security Administration be requested to honor payment, in whatever amount, of an itemized bill substantiating legitimate services to a deceased beneficiary.

"The Committee recommends acceptance of this substitute resolution and I so move."

By official action Substitute Resolution No. 33-73 was adopted.

#### RESOLUTION NO. 36-73

##### Revenue Sharing and Health and Medical Services

"The Committee next considered Resolution No. 36-73 which as originally submitted was restricted to Huron County. The Huron County Delegation in a magnanimous gesture of sharing their experience with the remainder of the state agreed to an amendment of their resolution as follows:"

#### AMENDED RESOLUTION NO. 36-73

WHEREAS, Congress recently has passed the Revenue Sharing Act, and

WHEREAS, It was reported by the Huron County Commissioners that this Act makes funds available for expenditure for health and/or medical services for the residents of Huron County and other counties, THEREFORE BE IT

RESOLVED, That OSMA offer all county commissioners the suggestions, and guidance of the local county medical society prior to expenditure of such funds for health and/or medical services, and, BE IT FURTHER

RESOLVED, That the House of Delegates of the Ohio State Medical Association distribute this resolution to the various county medical societies with the hope that the county commissioners of the respective 88 counties in Ohio might see the wisdom of this resolution and seize the opportunity to help their own county residents who are in need of financial assistance for their health and medical care services.

"The Committee recommends the acceptance of this amended resolution and I so move."

By official action Amended Resolution No. 36-73 was adopted.

#### RESOLUTION NO. 46-73

##### Medicare Reimbursement

"The final resolution for consideration by this Committee was Resolution No. 46-73 Medicare Reimbursement (by the Summit County Medical Society). The resolution as submitted alluded to the fact that the Medicare administrative regulations presently permit reimbursement for only one visit per calendar month for patients in nursing homes or extended care facilities. A review of 'Part B Intermediary Letter, No. 70-32, November 1970' entitled Medicare Reimbursement for Physicians' Visits to Nursing Home Patients read as follows: 'Physicians' visit to nursing home pa-

tients—frequency of visit—Medicare reimbursement can be made for one physician visit to the same patient in a nursing home in a calendar month, on the presumption that such a visit is medically necessary for a person whose condition requires him to reside in the home. Further visits are reimburseable only in the case of a claim in which the physician has adequately substantiated the need for more frequent visit to the specific patient. Back references: Paragraph 3110, 3190, 4030;

"The resolution as submitted was at variance with the last published regulation of the Medicare administrative program. Several examples were given by those participating in the discussion suggesting that the intermediary agent had an interpretation that did not conform with the written regulation. This Committee would like to suggest that The Council direct the appropriate committee to ascertain from the involved intermediary the reason for the obvious nonconformity with the written regulation.

"Because Resolution No. 46-73, as submitted, is an apparent misinterpretation of the written regulation this Committee recommends that it not be adopted and I so move."

By official action the House voted to reject Resolution No. 46-73.

"This Committee wishes to thank all of those who appeared before it to lend their collective efforts and wisdom to its deliberations. We also wish to thank those members of the staff who facilitate our work in its several dimensions. And I personally wish to thank each of the members of Resolutions Committee No. 3.

"Respectfully submitted: George J. Schroer, Shelby County; David A. Barr, Allen County; T. F. Moriarty, Henry County; Keith DeVoe, Jr., Franklin County; Edward E. Grable, Stark County; Carl A. Lincke, Carroll County; Robert A. Ringer, Guernsey County; A. Burton Payne, Lawrence County; Hall S. Wiedemer, Richland County; Robert S. Heidt, Hamilton County; Clarence L. Huggins, Chairman, Cuyahoga County."

The report of Resolutions Committee No. 3 as a whole, as amended, was approved by the House.

#### **Report of Resolutions Committee No. 4**

Dr. Frederick P. Osgood, Lucas County, reported for Resolutions Committee No. 4, of which he was chairman. The report read as follows:

"Resolutions Committee No. 4 considered thirteen (13) resolutions and a report from the Commission on Medical Education. We were pleased to have so many of the members of the Association and knowledgeable guests in attendance to present their views on the various resolutions. These were all carefully weighed and the following report is submitted."

#### **RESOLUTION NO. 1-73**

##### **Members in Training**

"The Reference Committee vote was divided, however, a majority were in agreement and for this reason. Mr. President, I move the adoption of Resolution No. 1-73."

#### **RESOLUTION NO. 1-73**

WHEREAS, It is desirable to define more accurately the status of those physicians who are pursuing studies and training in accredited programs, and

WHEREAS, It is desirable to increase the participation of such physicians in organized medicine, IT IS HEREBY

PROPOSED, That the Constitution and Bylaws of the Ohio State Medical Association be amended as follows:

#### **CONSTITUTION**

##### **ARTICLE III**

**Section 1. Classes of Members.** No. 3. Delete "Resident and Intern Members" and insert "Members in Training."

**Section 2. Voting Members.** The voting members of this Association shall consist of each of those physician members of the component societies who has complied with the eligibility requirements of Chapter 1 of the Bylaws of this Association, and who has been certified by the appropriate officer of his component society as being an active member or a Member in Training in good standing of such society, and whose dues and assessments in this Association for the current year have been received at the headquarters of this Association; provided, however, that the foregoing provision regarding receipt of dues and assessments shall not apply to members exempted from the payment of dues and assessments under the provisions of Chapter 2 of the Bylaws of this Association, or to members whose dues and assessments have been waived.

##### **ARTICLE VI**

**Section 2. Election and Eligibility.** The officers of this Association shall be elected by the House of Delegates during the Annual Meeting. No person shall be eligible for an elective office who has not been (a) an active member or Member in Training of this Association during the entire preceding two years. The terms of the officers of this Association shall be such as are prescribed by Chapter 6 of the Bylaws of this Association.

#### **BYLAWS**

##### **CHAPTER 1**

##### **Membership**

##### **Section 2. Classification of Membership.**

(a) Active Members. Active Members of this Association shall comprise all the active members in good standing of the several component societies. Active Mem-



bers in good standing of this Association shall have the right to vote and hold office.

(b) \* \* \*

Delete present (c) and insert:

(c) **Members in Training.** Members in training shall comprise all those members in good standing of the several component societies who are pursuing studies and training in a program accredited by the American Medical Association and its associated groups. Members in training in good standing of this Association shall have the right to vote and hold office.

**Section 3. Eligibility.** Delete "or resident or intern" in first sentence.

## CHAPTER 4

### The House of Delegates

**Section 2. Ratio of Representation.** Each component society shall be entitled to one delegate in the House of Delegates for each one hundred (100) Active, Associate Members, and Members in Training or fraction thereof, in good standing in this Association; provided, however, that each component society shall be entitled to at least one delegate and one alternate delegate. The names of such delegates and alternate delegates shall be submitted to the headquarters of this Association at least thirty (30) days prior to the first day of the meeting of the House of Delegates. In case a delegate or alternate delegate of a component society is unable to serve, the president or secretary of such society may at any time certify to the Chairman of the Committee on Credentials the name of an Active Member or Member in Training in good standing to serve in the place of such absent delegate or absent alternate delegate.

## CHAPTER 11

### Membership in Component Societies

**Section 1. Qualifications for Membership in a Component Society.** To be eligible for active membership, associate membership or In Training Membership in a component society, or other probationary or provisional type of membership of limited duration, a person must possess all of the following qualifications:

\* \* \*

Provided, however, that where it is more convenient for a member of a component society to attend the meetings of another component society located in a county adjoining that in which he holds such membership, such member, upon application to, and approval by, both the society in which he holds such membership and the society in such adjoining county, shall be entitled to a transfer of his membership to the latter society; and, provided further, that no person possessing an active membership, associate membership, or In Training Membership, or probationary or provisional type of membership, of limited duration, in one component society may acquire or possess at the same time an active membership, or an associate or probationary or provisional type of membership of limited duration, in another component society.

By official action, Resolution No. 1-73 was adopted.

### RESOLUTION NO. 8-73

Compulsory Formal Postgraduate Education  
and  
Basic Recommendations of the Commission on  
Medical Education to the House of Delegates

"Resolution No. 8-73 and Report of the Commission on Medical Education were considered

together in the discussion, however, there were some alterations necessary on Resolution No. 8-73 to make it applicable to a State resolution and for this reason, I offer Substitute Resolution No. 8-73, incorporating all of the original WHEREAS's, and modifying the first RESOLVE as follows:

**RESOLVED,** That the Ohio State Medical Association is strongly opposed to any discriminatory government rules and regulations regarding compulsory formal postgraduate education and re-examination for licensure.

"The second RESOLVE should be deleted."

### AMENDED SUBSTITUTE RESOLUTION NO. 8-73

#### Compulsory Formal Postgraduate Education

**WHEREAS,** Physicians as a profession require more education and training prior to licensure than any other profession

**WHEREAS,** Hospital privileges are granted to physicians only in those fields where expertise has been proven by certification of apprenticeship

**WHEREAS,** The professional conduct and ethics of the medical profession require free dissemination of knowledge and new technics to its members

**WHEREAS,** The medical profession has traditionally and unselfishly assisted in the training and education of new and old members as has no other profession

**WHEREAS,** This system without government interference has resulted in the most knowledgeable and well trained physicians in the world, **THEREFORE, BE IT**

**RESOLVED,** That the Ohio State Medical Association is strongly opposed to any discriminatory government rules and regulations regarding compulsory formal post-graduate education and re-examination for licensure and **BE IT FURTHER**

**RESOLVED, THAT ASSESSMENT OF A PHYSICIAN'S COMPETENCE BY HIS PERFORMANCE IS A PREFERABLE TECHNIQUE, AND AS A REALISTIC GOAL OF MEDICINE SHOULD BE PURSUED.**

"Mr. President, I recommend adoption of Amended Substitute Resolution No. 8-73, as amended.

"Further, Mr. President, I recommend the approval of the Commission on Medical Education Report."

By official action the House voted to amend Substitute Resolution No. 8-73 as indicated by the additions set forth in capital letters, then adopted it.

By official action the House approved the report of the Commission on Medical Education.

### RESOLUTION NO. 17-73

#### The Ohio Medical Indemnity

"This resolution was submitted by the Ross County Medical Society and it was the opinion of your Reference Committee that with some modi-



fications, it should be submitted to the House of Delegates. I submit the following resolution:"

#### AMENDED SUBSTITUTE RESOLUTION NO. 17-73

WHEREAS, The Ohio Medical Indemnity, Inc. (OMI), in making payment for physician's services, may pay less than the fee charged, and

WHEREAS, This is their privilege under the terms of their contracts, and

WHEREAS, OMI may send a letter accompanying the payment which implies, but does not clearly state, that the fee is more than the physician's usual, customary and reasonable fee, and

WHEREAS, This action leads to dissatisfaction and misunderstanding by the patient and is a disservice to the physician and the medical profession, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association recommend to OMI that any of its letters to patients state ~~only~~ that under the terms of the patient's contract, AFTER PEER REVIEW AND IN ACCORDANCE WITH OSMA POLICY, OMI is not obligated to pay the entire fee for the services provided.

"Mr. President, I move adoption of Amended Substitution Resolution No. 17-73."

By official action Substitute Resolution No. 17-73 was amended as indicated by strike outs for deletions and capital letters for additions and was adopted.

#### RESOLUTION NO. 20-73

##### Medicine and Religion Academic Curriculum

"We heard convincing arguments in support of this resolution. Deliberations developed concern over the second RESOLVE and the third RESOLVE, and for this reason we submit Amended Resolution No. 20-73. The second RESOLVE is amended as follows:

RESOLVED, That the appropriate committee of the Ohio State Medical Association be charged with implementing this resolution.

"The third RESOLVE is deleted. Mr. President, I move the acceptance of Amended Resolution No. 20-73."

#### AMENDED RESOLUTION NO. 20-73

WHEREAS, It is recognized that comprehensive cooperative, professional effort is necessary for the care and treatment of the "whole man," and

WHEREAS, Physicians and clergymen are vital components of the health care team, and

WHEREAS, Professional training and education are necessary to prepare physicians and clergymen to assume their role on the health care team, and

WHEREAS, The American Medical Association and the Ohio State Medical Association Committee on Medicine and Religion are interested in promoting cooperation between Medicine and Religion at the academic level, and

WHEREAS, Physicians representing Ohio medical schools, and clergymen representing several theological seminaries have expressed their interest and offered assistance in establishing reciprocal academic credit courses in Ohio medical schools and theological seminaries; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association encourage and assist Ohio medical schools and theological seminaries to establish reciprocal academic credit courses on Medicine and Religion and BE IT FURTHER

RESOLVED, That the appropriate committee of the Ohio State Medical Association be charged with implementing this resolution.

By official action the House adopted Amended Resolution No. 20-73.

#### RESOLUTION No. 24-73

##### Conflict of Interest

"As long as the memories of the members of this Committee runneth not to the contrary, doctors have been urged to take an active part in all community affairs. There should be, because of this, a conflict of interest based on the intensity of an individual's community activity. The discussion further brought out the advisability of forthrightness when one is making a statement and the need for clarifying his position or the platform from which he speaks. Since we are assuming that all statements or peers are made with an honest intent, the Committee recommends that this resolution not be adopted, and, Mr. President, I so move."

By official action the House voted to reject Resolution No. 24-73.

#### RESOLUTION No. 28-73

##### Condemning Euthanasia and the Abuse of the Phrase "Death with Dignity"

"The Reference Committee notes that the author of this resolution was not present. There was some ambiguity throughout the WHEREAS's and the RESOLVE's. For the above reason, the Committee is impelled to recommend that this resolution as submitted not be adopted and, Mr. President, I so move."

By official action the House voted to reject Resolution No. 28-73.

#### RESOLUTION No. 37-73

##### Out-Patient Diagnostic Procedures

"This resolution is addressed to a situation which does not presently exist. There are policies available which insure Out-Patient Diagnostic Procedures. Mr. President, I move that Resolution No. 37-73 not be adopted."

By official action the House voted to reject Resolution No. 37-73.

*(Continued on Next Page)*

#### RESOLUTION No. 38-73

##### Insurance Companies Inimical to the Private Practice of Medicine

"The discussion pertinent to this resolution resulted in an amendment of the original resolution by deletion. The deletion consists of the removal of the word Hospitalization in the first WHEREAS and in the subsequent first RESOLVE, and Mr. President, with these simple changes, I move its adoption."

#### AMENDED RESOLUTION No. 38-73

WHEREAS, Some Insurance Companies propose to render legal aid to their contractees when said contractees will refuse to pay the reasonable and customary fee submitted by a Private Practicing Physician for services rendered but, would rather prefer to pay a proposed "allowed" fee advised by the insurance company, and

WHEREAS, This proposed, espoused concept is inimical to the Preservation of Freedom in the Private Practice of Medicine necessary for the fuller mutual benefit of Patients and Physicians alike, and THEREFORE, BE IT

##### RESOLVED,

1. That the names of the Insurance Companies who are advocating this alien philosophy be made known to all the members of the Ohio State Medical Association.

2. That each member, thereafter, take appropriate action, in his best judgment, necessary to continue to preserve an atmosphere of Freedoms for both Patients and Physicians alike; this atmosphere being necessary to enhance mutual respect, trust, and dignity — which are necessary for the mutual benefit of Patients and Physicians alike.

3. That each State Medical Association receive a copy of this Resolution from The Ohio State Medical Association.

By official action the House voted to adopt Resolution 38-73, as amended.

#### RESOLUTION No. 43-73

##### Malpractice "Nuisance" Suits

"Since the time this resolution has been submitted, action has been taken upon the law in California. The dollar amount of the bond suggested might preclude the introduction of a legitimate suit. For this reason, the Reference Committee recommends that the portion of the resolution to be amended read as follows:"

RESOLVED, That the Ohio State Medical Association encourage the Ohio State Legislature to adopt a law similar to that in California whereby a plaintiff must post a bond when instituting a malpractice claim which then would be forfeited to the defendant if the case were lost or refused consideration.

"Mr. President, I move the adoption of this resolution as amended."

#### AMENDED RESOLUTION No. 43-73

WHEREAS, The number of malpractice suits has increased greatly in recent years, and

WHEREAS, A good proportion of these are "nuisance" suits without much merit but involving considerable time and expense to those involved, and

WHEREAS, This lost time could be better employed in providing needed patient care and some deterrent is needed to curb unwarranted suits, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association encourage the Ohio State Legislature to adopt a law similar to that in California whereby a plaintiff must post a bond when instituting a malpractice claim which then would be forfeited to the defendant if the case were lost or refused consideration.

By official action the House voted to adopt Amended Resolution No. 43-73.

#### RESOLUTION No. 47-73

##### Ohio Medical Indemnity, Inc.

"Considerable testimony concerning this resolution was heard pointing out several inaccuracies in several of the WHEREAS's. The discussion further pointed out that there was an on-going assessment because of the organizational setup. It is recommended that Resolution No. 47-73 not be adopted. This recommendation is made with one abstention in the committee vote, and Mr. President, I so move."

By official action the House voted to reject Resolution No. 47-73.

#### RESOLUTION No. 56-73

##### Life Active Member

"This resolution was submitted by The Council of the Ohio State Medical Association. It has received careful consideration and endorsement by The Council, and, Mr. President, I move the adoption of this resolution."

#### RESOLUTION No. 56-73

WHEREAS, The Ohio State Medical Association is involved in a program of expansion of services and facilities, and

WHEREAS, The financial position of OSMA would be enhanced by a predictable source of capital, thereby negating the necessity of long-term fiscal encumbrances and

WHEREAS, The new Association headquarters represents a possible long-term indebtedness, and

WHEREAS, It is desirable to provide a new classification of members of OSMA to achieve these objectives, THEREFORE, BE IT

RESOLVED, That the Bylaws of the Ohio State Medical Association be amended as follows:

In Chapter 1 (Membership), Section 2 (Classification of Membership) insert:

(g) Life Active Members.

Any active member of this Association who shall make a single payment of \$1,250.00 after

January 1, 1974, for lifetime membership dues, shall become a Life Active Member of this Association and shall not be assessed additional membership dues during his lifetime. This membership shall be limited to the first 500 active members who make a single lifetime membership dues payment of \$1,250.00 after January 1, 1974.

By official action **Resolution No. 56-73** was adopted.

#### **RESOLUTION No. 57-73**

##### **Recruitment of Medical Students**

"This resolution received considerable comment and, in the main, the approbation of the majority. Clarity requires modification of the WHEREAS's and the final RESOLVE. For this reason, a substitute resolution is submitted as follows:"

#### **SUBSTITUTE RESOLUTION No. 57-73**

WHEREAS, The University of Cincinnati School of Medicine has in recent years accepted 42.7% of its freshman class from out-of-state applicants which is higher than any similar state-supported school in the U.S.

WHEREAS, These students quite possibly will never become a part of the medical community in Ohio;  
**THEREFORE, BE IT**

**RESOLVED**, That the Ohio State Medical Association work with the Deans of the University of Cincinnati School of Medicine in an effort to recruit more medical students from the state of Ohio.

"Mr. President, I move the adoption of this substitute resolution."

By official action **Substitute Resolution No. 57-73** was adopted.

#### **RESOLUTION No. 58-73**

##### **Discrimination Against Non-Resident Students**

"This resolution was submitted by The Council of the Ohio State Medical Association. The Committee regrets that no one appeared to discuss it during the deliberations. It was the consensus that this resolution was in conflict with Resolution No. 57-73. For this reason, it is recommended that it not be adopted, and, Mr. President, I so move."

By official action the House voted to reject **Resolution No. 58-73**.

"Mr. President, the Committee wishes to thank all those who appeared before it and shared their knowledge with us so that this report could be drafted. The Chairman is grateful to the staff and the members of the Committee without whose support this report could not have been submitted.

The following were the members of the Committee: Andrew J. Weiss, Hamilton County; Ernest H. Winterhoff, Clark County; James H.

Steiner, Logan County; Carl G. Madsen, Jr., Lake County; E. Joel Davis, Stark County; Norman L. Wright, Coshocton County; Richard E. Hartle, Fairfield County; Chester H. Allen, Scioto County; Sol Maggied, Madison County; Charles G. Adams, Lorain County; Frederick P. Osgood, Chairman, Lucas County."

The Report of Resolutions Committee No. 4 as a whole, as amended, was approved by the House.

#### **Appreciation Expressed**

Dr. Schultz asked Mrs. Gail Dodson to stand, as he expressed his thanks to her for her successful organization of the 1973 Annual Meeting in this her first year as convention coordinator.

Dr. Schultz praised all members of the staff for the execution of their assigned duties during the meeting.

#### **Inaugural Ceremony**

Dr. Robeck administered the presidential oath of office to Dr. Oscar W. Clarke and Dr. Schultz, retiring President, presented to Dr. Clarke the official gavel and the President's Medallion. Dr. Robeck then presented President's Medallion pins to Dr. and Mrs. Schultz and the certificate of honor to Dr. Schultz. Dr. Clarke presented to Dr. Schultz the Past Presidents' Button.

#### **Committees Named**

Dr. Clarke presented the following committee appointments and they were officially approved by the House of Delegates:

**Committee on Education** — Dr. John G. Sholl, Cleveland, reappointed chairman for ensuing year and reappointed member of the Committee for a term of five years.

**Committee on Judicial and Professional Relations** — Dr. Homer A. Anderson, Columbus, reappointed chairman for ensuing year; Dr. P. John Robeck, Cleveland, appointed for a term of five years.

**Committee on Membership and Planning** — Dr. William M. Wells, Newark, reappointed chairman for ensuing year; Dr. William R. Schultz, Wooster, appointed for a term of five years.

**Committee on Public Relations** — Dr. Luther W. High, Millersburg, reappointed chairman for ensuing year; Dr. Richard L. Fulton, Columbus, appointed for a term of five years.

**Committee on Scientific Work** — Dr. Jack E. Tetrick, Columbus, reappointed chairman for





# Attendance of Delegates (contd.)

| County           | Delegate                   | First Session | Final Session | County                   | Delegate                | First Session | Final Session |
|------------------|----------------------------|---------------|---------------|--------------------------|-------------------------|---------------|---------------|
|                  |                            |               |               | NINTH DISTRICT           |                         |               |               |
|                  | Nicholas G. DePiero        | x             | x             | GALLIA                   | Thomas P. Price, Jr.    | x             | x             |
|                  | John J. Gaughan            | x             | x             | HOCKING                  | L. W. Starr             | x             | x             |
|                  | Clarence L. Huggins        | x             | x             | JACKSON                  | Carl J. Greever         | x             | x             |
|                  | Roscoe J. Kennedy          | x             | x             | LAWRENCE                 | A. Burton Payne         | x             | x             |
|                  | John A. Kinieck            | x             | x             | MEIGS                    | Roger Daniels           | x             | x             |
|                  | Vincent T. LaMaida         | x             | x             | PIKE                     | Robert T. Leever        | x             | x             |
|                  | George P. Leicht           | x             | x             | SCIOTO                   | Chester H. Allen        | x             | x             |
|                  | Leonard L. Lovshin         | x             | x             | VINTON                   |                         |               |               |
|                  | Hermann Menges, Jr.        | x             | x             | TENTH DISTRICT           |                         |               |               |
|                  | James R. O'Malley          | x             | x             | DELAWARE                 | Robert S. Caulkins, Jr. | x             | x             |
|                  | George W. Petznick         | x             | x             | FAYETTE                  |                         |               |               |
|                  | John H. Sanders            | x             | x             | FRANKLIN                 | Homer A. Anderson       | x             | x             |
|                  | A. Benedict Schneider, Jr. | x             | x             |                          | Michael A. Anthony      | x             | x             |
|                  | Frederick T. Suppes        | x             | x             |                          | Robert C. Atkinson      | x             | x             |
|                  | William V. Trowbridge      | x             | x             |                          | James E. Barnes         | x             | x             |
|                  | Howard S. VanOrdstrand     | x             | x             |                          | Joseph A. Bonta         | x             |               |
|                  | Julius Wolkin              | x             |               |                          | Keith DeVoe, Jr.        | x             | x             |
|                  | W. W. Tuckerman            |               | x             |                          | Richard L. Fulton       | x             | x             |
| GEAUGA           | Alton W. Behm              | x             | x             |                          | John N. Meagher         | x             | x             |
| LAKE             | Carl G. Madsen, Jr.        | x             | x             |                          | H. William Porterfield  | x             | x             |
|                  | Wesley J. Pignolet         | x             | x             |                          | James C. Good           |               | x             |
| SIXTH DISTRICT   |                            |               |               | KNOX                     | Henry T. Lapp           | x             | x             |
| COLUMBIANA       | William S. Banfield        | x             | x             | MADISON                  | Sol Maggied             | x             | x             |
| MAHONING         | John C. Melnick            | x             | x             | MORROW                   | Joseph P. Ingmire       | x             | x             |
|                  | Felix A. Pesa              |               | x             | PICKAWAY                 | Jasper M. Hedges        | x             | x             |
|                  | C. E. Pichette             | x             | x             | ROSS                     | Joseph S. McKell        | x             | x             |
|                  | Jack Schreiber             | x             | x             | UNION                    |                         |               |               |
|                  | William E. Sovik           | x             |               | ELEVENTH DISTRICT        |                         |               |               |
| PORTAGE          | George R. Sprogis          | x             |               | ASHLAND                  | Jon H. Cooperrider      | x             | x             |
|                  | Jack Fulton                |               | x             | ERIE                     | S. Baird Pfahl, Jr.     | x             | x             |
| STARK            | E. Joel Davis              | x             | x             | HOLMES                   | Luther W. High          | x             | x             |
|                  | Frank O. Goodnough         | x             | x             | HURON                    | Nino M. Camardese       | x             | x             |
|                  | Edward E. Grable           | x             | x             | LORAIN                   | Charles G. Adams        | x             | x             |
|                  | William A. White, Jr.      | x             | x             |                          | Henry E. Kleinhenz      | x             | x             |
| SUMMIT           | Rocco M. Antenucci         | x             | x             |                          | James T. Stephens       | x             | x             |
|                  | Lynn F. DeFreest           | x             | x             | MEDINA                   | Richard W. Avery        | x             | x             |
|                  | William Dörner             | x             | x             | RICHLAND                 | Harold F. Mills         | x             | x             |
|                  | John C. Johns              | x             | x             |                          | Hall S. Wiedemer        | x             | x             |
|                  | Emmett P. Monroe           | x             | x             | WAYNE                    | A. Burney Huff          | x             | x             |
|                  | Robert R. Clark            | x             | x             | OFFICERS                 |                         |               |               |
| TRUMBULL         | Joseph L. Logan            | x             | x             | (Members of The Council) |                         |               |               |
|                  | Robert J. Paul             | x             | x             | President                | William R. Schultz      | x             | x             |
| SEVENTH DISTRICT |                            |               |               | President-Elect          | Oscar W. Clarke         | x             | x             |
| BELMONT          | Luis Vazquez               | x             | x             | Past President           | P. John Robeck          | x             | x             |
| CARROLL          | Carl A. Lincke             | x             |               | Secretary-               |                         |               |               |
| COSHOCTON        | Norman L. Wright           |               | x             | Treasurer                | James L. Henry          | x             | x             |
| HARRISON         | Elias Freeman              | x             |               | First District           | Stephen P. Hogg         | x             | x             |
|                  | Janis Trupovnieks          |               | x             | Second                   | James G. Tye            | x             | x             |
| JEFFERSON        | Sanford Press              | x             | x             | Third                    | John C. Smithson        | x             | x             |
| MONROE           |                            |               |               | Fourth                   | George N. Bates         | x             | x             |
| TUSCARAWAS       | Philip T. Doughten         | x             | x             | Fifth                    | David Fishman           | x             | x             |
| EIGHTH DISTRICT  |                            |               |               | Sixth                    | Maurice F. Lieber       | x             | x             |
| ATHENS           | Leland P. Randles          | x             | x             | Seventh                  | Robert E. Rinderknecht  | x             | x             |
| FAIRFIELD        | Richard E. Hartle          | x             | x             | Eighth                   | William M. Wells        | x             | x             |
| GUERNSEY         | Robert A. Ringer           | x             | x             | Ninth                    | Thomas W. Morgan        | x             | x             |
| LICKING          | Irving A. Nickerson        | x             | x             | Tenth                    | James C. McLarnan       | x             | x             |
| MORGAN           | Henry Bachman              |               | x             | Eleventh                 | Robert G. Thomas        | x             | x             |
| MUSKINGUM        | Walter B. Devine           | x             | x             |                          |                         |               |               |
| NOBLE            |                            |               |               |                          |                         |               |               |
| PERRY            | Arthur L. Dobosiewicz      | x             |               |                          |                         |               |               |
| WASHINGTON       | Gregory B. Krivchenia      | x             | x             |                          |                         |               |               |
| Total            |                            |               |               |                          |                         | 161           | 160           |

# Outstanding Exhibits Recognized at 1973 OSMA Annual Meeting

**S**EVERAL OUTSTANDING EXHIBITS were selected by a Judging Committee at the 1973 OSMA Annual Meeting for special recognition. The selected exhibits were part of a display of some 35 Scientific Exhibits, 24 Health-Education Exhibits, and 68 Technical Exhibits on the Exhibition Floor of the Veterans Memorial Building in Columbus.

Sponsors of the recognized exhibits were presented plaques to be displayed on their respective booths and kept as permanent mementos, with certificates indicating the various categories of awards authorized by planners of the Annual Meeting.

Following are brief summaries of the outstanding exhibits and awards presented. Additional information indicating the scope of subject matter covered will be published in forthcoming issues of *The Journal*.

**Gold Award in Original Investigation:** The exhibit, "Breast Cancer Bone Pain Relief with L-Dopa," sponsored by John Peter Minton, M.D., Department of Surgery, Ohio State University College of Medicine, Columbus. This exhibit also was awarded the **Cancer Award**, the citation and monetary gift from the Ohio Chapter, American Cancer Society.

**Silver Award in Original Investigation:** The exhibit, "The Dizzy Patient (Current Surgical Management)," sponsored by Edward L. Hendershot, M.D., and James W. Wood, M.D., Department of Otolaryngology, Lutheran Medical Center, Cleveland.

**Bronze Award in Original Investigation:** The exhibit, "Vasectomy Using Implantable Prosthesis," sponsored by Robert T. Bliss, M.D., Cincinnati.

**Honorable Mention in Original Investigation:** The exhibit, "Seven Years Experience—Outpatient Office Surgery," sponsored by H. William Porterfield, M.D., John L. Terry, M.D., and Lester R. Mohler, M.D., Columbus.

**Honorable Mention in Original Investigation:** The exhibit, "Selection of Initial Antibiotic Therapy in Appendicitis with Rupture or Abscess,"

sponsored by Sidney Miller, M.D., Rudolf Hofmann, M.D., Frederick A. Hillis, M.D., and Robert F. Finley, M.D., Miami Valley Hospital, Dayton.

**Honorable Mention in Original Investigation:** The exhibit, "Trigeminal Neuralgia—A New Approach to Surgical Treatment," sponsored by John M. Tew, Jr., M.D., and Frank H. Mayfield, M.D., Good Samaritan, and Christ Hospitals, Cincinnati.

**Gold Award in Teaching:** The exhibit, "Total Knee Replacement," sponsored by Thomas H. Mallory, M.D., Columbus.

**Silver Award in Teaching:** The exhibit, "Diagnosis and Treatment of Acoustic Tumors," sponsored by Sabino T. Baluyot, M.D., and John M. Tew, Jr., M.D., Cincinnati.

**Bronze Award in Teaching:** The exhibit, "Immunofluorescent Studies in Autoimmune Diseases," sponsored by Sharad D. Deodhar, M.D., Ph.D., Cleveland Clinic Educational Foundation.

**Honorable Mention in Teaching:** The exhibit, "Extragenital Cytology," sponsored by the following team from the Department of Pathology, Ohio State University College of Medicine, Columbus: Mrs. Susan Chappell, Mr. Frank Cossu, Katherine Skitarelic, M.D., Mrs. Mary Snyder, Emmerich von Haam, M.D., and Miss Susan Wilson.

**Honorable Mention in Teaching:** The exhibit, "Geometric Total Knee Replacement Arthroplasty," sponsored by the following Cleveland Clinic Educational Foundation team: Alan H. Wilde, M.D., H. Royer Collins, M.D., Charles M. Everts, M.D., Carl L. Nelson, M.D., and Kenneth E. DeHaven, M.D.

**Honorable Mention in Teaching:** The exhibit, "Repair of VesicoVaginal Fistulae," sponsored by Henry A. Wise II, M.D., and Edward V. Bennett, M.S., Ohio State University College of Medicine, Columbus.

**Special Award:** The Health Education exhibit, "Medical Advances Institute—PSRO; the How, What, and Why in Ohio."



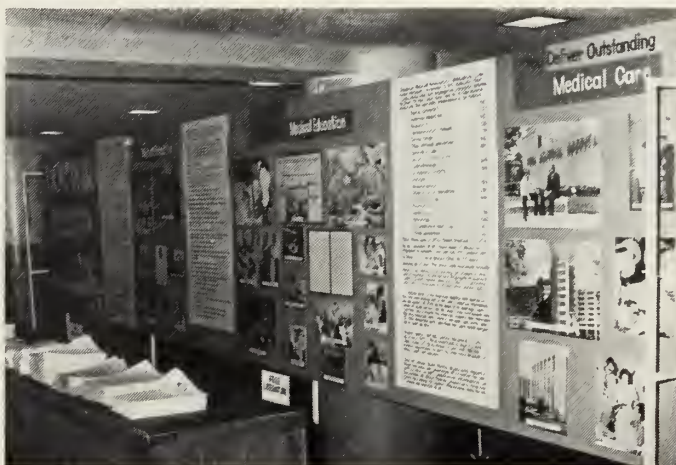
# Annual Meeting Photo Features



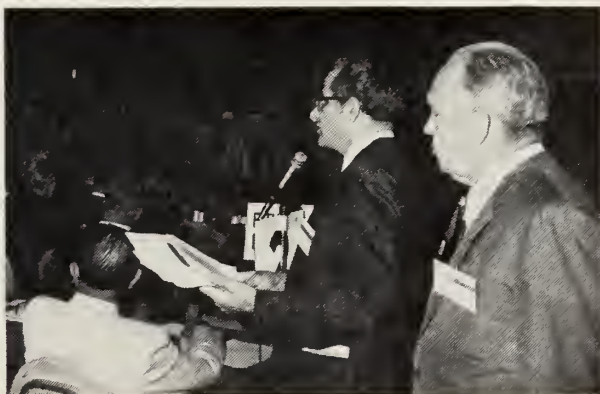
Dr. Anthony Ruppertsberg, Chairman of the OSMA Committee on Maternal Health, testifies before Resolutions Committee No. 2.



At the Final Session of the House of Delegates, Dr. William R. Schultz, left, 1972-1973 President, exchanges greetings with Incoming President Oscar W. Clarke who now wears the President's Medallion.



Educare '73 was the theme of the Annual Meeting and this exhibit on display near the Registration area graphically depicted the scope of that theme. The subject was expanded under three general headings: "You Participate in Medical Education" — "You Continue Your Medical Education" — "You Deliver Outstanding Medical Care."



During House debate on resolutions, Delegates await their turns at the mike.



# Annual Meeting Photo Features



At the General Session on Tuesday morning, this panel discussed "Quality Medical Care in Government—Will PSRO Do It?" From left are: Dr. William I. Bauer, PSRO Director, Washington; Thomas Tierney, of the Social Security Administration, Washington; Dr. John Cashman, Director of the Ohio Department of Health; Dr. William A. Millhon, panel chairman; Dr. James M. Garvey, Jr.; Dr. Paul Metzger, medical director, Nationwide Insurance Company; Dr. Oscar W. Clarke, OSMA Incoming President; and Dr. Peter Overstreet.



"Sports Medicine" was the subject and among panel participants were, from left, Dr. Robert Murphy, Columbus; Dr. Stephen E. Reid, Northwestern University; Dr. Thomas R. Peterson, University of Michigan; W. W. "Woody" Hayes, head football coach at OSU; and Dr. John N. Meagher, Columbus.



Alan W. Hart, head athletic trainer at OSU, discusses protective equipment as part of the "Sports Medicine" program.



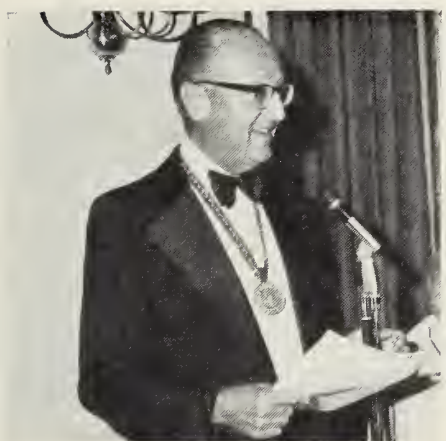
The House of Delegates with Dr. Luther High and Jon Cooperrider in the foreground.



Dr. Raymond T. Holden, Washington, D.C., member of the AMA Board of Trustees brings greetings to the House of Delegates with a mike adjustment assistance from Hart Page, OSMA Executive Director.



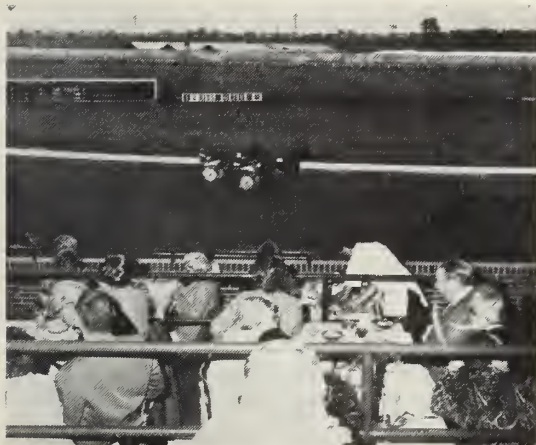
# Annual Meeting Photo Features



1972-1973 President William R. Schultz, wears the President's Medallion as he presides at the Monday evening Council dinner honoring Past Presidents.



An excellent attendance was registered at the Annual OMPAC luncheon held this year in the Sheraton-Columbus Motor Hotel.



Members and guests enjoyed a leisurely dinner during "OSMA Night at Scioto Downs" as trotters in the coming events warm up on the track.



Dr. Samuel Saslaw leads discussion in "Current Concepts in Antibiotic Therapy" at one of the breakfast postgraduate courses held at the Sheraton-Columbus Hotel.



Absorbed in their program, these members of the Pre-Med Club made the journey from Cuyahoga Falls for a view of the Annual Meeting under sponsorship of the Summit County Medical Society.



The Press was well represented at the Annual Meeting. Here Dan Clancy, Columbus Dispatch science writer, interviews Dr. Mary S. Calderone, of New York City, one of the principal speakers in the "Sexual Counseling" session.



# Annual Meeting Photo Features



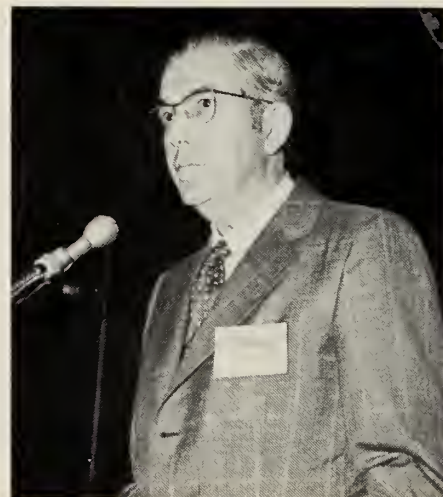
Dr. Robert G. Page, Dean of the Medical College of Ohio at Toledo, accepts a check from Dr. Philip B. Hardyman, chairman of the AMA-ERF Committee.



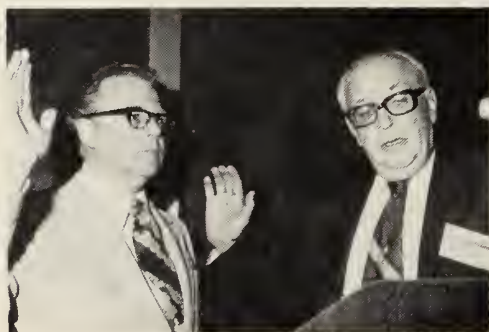
Outside the "Sports Medicine" meeting room, Tom Ryan, WBNS-TV, Columbus, commentator, interviews Dr. Sol Maggied, chairman of the Section on Sports Medicine and the Joint Advisory Committee on Sports Medicine.



The representatives of Ohio's four medical schools who received AMA-ERF checks are, from left, Dr. Richard D. Ruppert, Ohio State University College of Medicine; Dr. David Fishman, Case Western Reserve University School of Medicine; Dr. Robert S. Daniels, University of Cincinnati College of Medicine; and Dr. Robert G. Page, Medical College of Ohio at Toledo.



Dr. Albert B. Huff, of Wooster, chairman of the Nominating Committee, reports to the House.



Incoming President Oscar W. Clarke takes the oath of office, administered by Past President P. John Robeck at the final session of the House of Delegates.



Not even the camera could distract the attention of this group as they concentrate on an early morning post-graduate course speaker.

# Annual Meeting Photo Features



Certificates of Appreciation were presented to several members who are retiring from activities on OSMA Committees. From left, Dr. P. John Robeck, Ohio Medical Indemnity Liaison Committee; Dr. H. William Porterfield, Committee on Medical Care Programs; Dr. Robert E. Zipf, Committee on Scientific Work; Dr. Drew L. Davies, Military Advisory Committee; and Dr. Robert E. Howard, Committee on Public Relations.



Legal phases of medical organization transactions are a constant concern of the profession. Here James E. Pohlman, Columbus attorney and legal counsel for the OSMA, confers with President Schultz.



Betty and Gordon Moore as they were presented before the House of Delegates. As Executive Editor of *The Journal*, he was presented an engraved plaque commemorating 25 years of service with the Association. Both were presented watches on behalf of the Association by Dr. William R. Schultz, OSMA President.



Dr. Drew L. Davies, chairman of long standing for the OSMA Military Advisory Committee, thanks the House of Delegates after being presented a Certificate of Appreciation for his contribution to the medical profession through the work of that committee.



Columbus is justly proud of its on-the-scene emergency service and transportation facilities. A team was on hand near the entrance to the Exhibit Hall for part of the Annual Meeting to display the available equipment.



# Annual Meeting Photo Features



The Council dinner-meeting on Monday, May 7 was given in honor of OSMA Past Presidents. Present and shown in the photograph, front row, from left: Dr. George W. Petznick, Cleveland (1961-1962); Dr. Robert E. Tschantz, Canton (1964-1965); Dr. Carl A. Lincke, Carrollton (1949-1950); Dr. William R. Schultz, Wooster (1972-1973); Dr. Robert S. Martin, Zanesville (1957-1958) and Dr. Merrill D. Prugh, Dayton (1954-1955).

Back row, from left: Dr. Richard L. Meiling, Columbus (1956-1957); Dr. Robert E. Howard, Cincinnati (1967-1968); Dr. Harve M. Clodfelter, Columbus (1952-1953); Dr. Robert N. Smith, Toledo (1969-1970); Dr. P. John Robeck, Cleveland (1971-1972); Dr. Lawrence C. Meredith, Elyria (1966-1967); and Dr. Henry A. Crawford, Cleveland (1965-1966).

Present at the Annual Meeting, but not shown in the picture were Dr. Frank H. Mayfield, Cincinnati (1959-1960), and Dr. Richard L. Fulton, Columbus (1970-1971).



Dr. Jasper M. Hedges, Chairman of Resolutions Committee No. 2, returns from the rostrum following his committee's report.



Dr. and Mrs. James L. Henry take time for a bit of dinner dancing at the Monday evening Council dinner meeting.



# Annual Meeting Photo Features



Candidate for the youngest attendant at the Annual Meeting was this babe-in-arms. Dr. and Mrs. Thomas Moriarty, of Napoleon, posed with their family and a friend, Paula Clark, extreme right.



Stitch in time . . . Clara Cherry, of the Columbus Convention Bureau, takes time out at the Registration desk to aid Dr. Rocco Antenucci who snagged his jacket.



Dr. Frederick P. Osgood, Toledo, Chairman of Resolutions Committee No. 4, shown as he completed his report to the House.



In the Winner's Circle at Scioto Downs, Dr. and Mrs. William Schultz, center, present trophy. With the winner, My Butler, are Driver Larry Richard and the owners, Mr. and Mrs. May, with one of the younger generation.



The 1973 OSMA Distinguished Service Award recipient is Dr. Elizabeth Rowland Aplin, who was cited for contributions to Ohio medicine as medical director of the Ohio Bureau of Crippled Children's Services. Unable to be present in person, Dr. Aplin's award was accepted for her by her son Charles Aplin II and daughter-in-law Patricia.



Dr. W. J. Lewis, Dayton, Chairman of the Board of Directors, American Medical Political Action Committee, poses near the OMPAC exhibit booth with Mrs. Lewis and William Watson, of the AMPAC Headquarters office in Chicago.

# Annual Meeting Attendance

Virtually the Whole State Represented by Members  
Present; Comparison of Previous Years' Figures

PERHAPS AN ALL-TIME RECORD in number of counties represented at the 1973 OSMA Annual Meeting was made. All of Ohio's 87 counties which have resident members were represented by members registered at the meeting. Vinton County does not have a resident member at the present time. In all, 1,100 OSMA members were present. In addition, 130 guest physicians registered, plus 93 medical students. This makes a total of 1,323 physicians and future physicians in attendance. The total attendance was 3,014, which was broken down as follows: OSMA members, 1,100; guest physicians, 130; medical students, 93; Woman's Auxiliary, nurses, technicians, dentists, and miscellaneous guests, 1,260; health education, and technical exhibitors, 431.

Following are tabulated figures on Annual Meeting attendance.

## 1973 Annual Meeting Registration by Counties With OSMA Membership Data

| MEMBERSHIP       |                 |                |                                | MEMBERSHIP       |                 |                |                                |
|------------------|-----------------|----------------|--------------------------------|------------------|-----------------|----------------|--------------------------------|
| County           | Dec. 31<br>1972 | May 2,<br>1973 | Ann. Mtg.<br>Registra-<br>tion | County           | Dec. 31<br>1972 | May 2,<br>1973 | Ann. Mtg.<br>Registra-<br>tion |
| Adams .....      | 10              | 12             | 2                              | Lorain .....     | 226             | 222            | 19                             |
| Allen .....      | 136             | 132            | 18                             | Lucas .....      | 628             | 568            | 50                             |
| Ashland .....    | 26              | 30             | 5                              | Madison .....    | 17              | 17             | 6                              |
| Ashtabula .....  | 55              | 56             | 2                              | Mahoning .....   | 348             | 336            | 14                             |
| Athens .....     | 40              | 38             | 8                              | Marion .....     | 69              | 68             | 6                              |
| Auglaize .....   | 16              | 20             | 3                              | Medina .....     | 61              | 59             | 7                              |
| Belmont .....    | 59              | 58             | 8                              | Meigs .....      | 5               | 4              | 1                              |
| Brown .....      | 17              | 17             | 1                              | Mercer .....     | 19              | 18             | 2                              |
| Butler .....     | 206             | 202            | 20                             | Miami .....      | 64              | 66             | 11                             |
| Carroll .....    | 9               | 9              | 2                              | Monroe .....     | 2               | 3              | 1                              |
| Champaign .....  | 13              | 14             | 2                              | Montgomery ..... | 656             | 637            | 49                             |
| Clark .....      | 135             | 133            | 23                             | Morgan .....     | 4               | 4              | 1                              |
| Clermont .....   | 18              | 19             | 2                              | Morrow .....     | 7               | 7              | 4                              |
| Clinton .....    | 20              | 21             | 4                              | Muskingum .....  | 80              | 79             | 17                             |
| Columbiana ..... | 73              | 73             | 7                              | Noble .....      | 2               | 2              | 1                              |
| Coshocton .....  | 20              | 20             | 3                              | Ottawa .....     | 22              | 23             | 3                              |
| Crawford .....   | 40              | 36             | 9                              | Paulding .....   | 7               | 7              | 1                              |
| Cuyahoga .....   | 2,247           | 2,125          | 112                            | Perry .....      | 8               | 8              | 1                              |
| Darke .....      | 22              | 26             | 3                              | Pickaway .....   | 19              | 20             | 7                              |
| Defiance .....   | 29              | 26             | 3                              | Pike .....       | 12              | 8              | 2                              |
| Delaware .....   | 27              | 27             | 9                              | Portage .....    | 59              | 59             | 5                              |
| Erie .....       | 61              | 58             | 3                              | Preble .....     | 6               | 6              | 1                              |
| Fairfield .....  | 50              | 49             | 19                             | Putnam .....     | 11              | 10             | 3                              |
| Fayette .....    | 14              | 13             | 3                              | Richland .....   | 127             | 126            | 17                             |
| Franklin .....   | 964             | 867            | 266                            | Ross .....       | 42              | 43             | 13                             |
| Fulton .....     | 17              | 17             | 1                              | Sandusky .....   | 45              | 43             | 5                              |
| Gallia .....     | 34              | 33             | 7                              | Scioto .....     | 66              | 62             | 7                              |
| Geauga .....     | 30              | 30             | 5                              | Seneca .....     | 39              | 36             | 7                              |
| Greene .....     | 55              | 51             | 7                              | Shelby .....     | 18              | 19             | 3                              |
| Guernsey .....   | 23              | 20             | 2                              | Stark .....      | 357             | 344            | 25                             |
| Hamilton .....   | 1,331           | 1,237          | 86                             | Summit .....     | 600             | 578            | 25                             |
| Hancock .....    | 45              | 40             | 4                              | Trumbull .....   | 147             | 139            | 14                             |
| Hardin .....     | 28              | 23             | 5                              | Tuscarawas ..... | 52              | 51             | 9                              |
| Harrison .....   | 9               | 8              | 2                              | Union .....      | 17              | 17             | 2                              |
| Henry .....      | 13              | 12             | 2                              | Van Wert .....   | 18              | 19             | 5                              |
| Highland .....   | 17              | 17             | 2                              | Vinton .....     | 1               | 1              | —                              |
| Hocking .....    | 10              | 7              | 2                              | Warren .....     | 15              | 15             | 3                              |
| Holmes .....     | 9               | 9              | 4                              | Washington ..... | 33              | 35             | 8                              |
| Huron .....      | 31              | 32             | 8                              | Wayne .....      | 65              | 62             | 6                              |
| Jackson .....    | 13              | 11             | 1                              | Williams .....   | 19              | 21             | 4                              |
| Jefferson .....  | 78              | 75             | 7                              | Wood .....       | 42              | 41             | 4                              |
| Knox .....       | 32              | 33             | 3                              | Wyandot .....    | 10              | 10             | 4                              |
| Lake .....       | 120             | 121            | 8                              |                  |                 |                |                                |
| Lawrence .....   | 22              | 22             | 6                              |                  |                 |                |                                |
| Licking .....    | 76              | 76             | 15                             |                  |                 |                |                                |
| Logan .....      | 15              | 15             | 6                              |                  |                 |                |                                |
|                  |                 |                |                                | Honorary .....   | 5               | 5              | 2                              |
|                  |                 |                |                                | TOTAL .....      | 10,365          | 9,868          | 1,100                          |



# OSMA Annual Meeting Registration — 1919 to 1973

| Year | Place                            | Members | Guest<br>Physicians | Medical<br>Students | Woman's Aux.:<br>Mis. Guests | Sc. and Tech.<br>Exhibitors | Total |
|------|----------------------------------|---------|---------------------|---------------------|------------------------------|-----------------------------|-------|
| 1919 | Columbus .....                   | 1173    |                     |                     | 264                          | 92                          | 1539  |
| 1920 | Toledo .....                     | 860     |                     |                     | 105                          | 80                          | 1062  |
| 1921 | Columbus .....                   | 1275    |                     |                     | 104                          | 96                          | 1503  |
| 1922 | Cincinnati .....                 | 1066    |                     |                     | 184                          | 70                          | 1341  |
| 1923 | Dayton .....                     | 1117    |                     |                     | 202                          | 76                          | 1414  |
| 1924 | Cleveland .....                  | 1301    |                     |                     | 180                          | 109                         | 1603  |
| 1925 | Columbus .....                   | 1204    |                     |                     | 361                          | 107                         | 1689  |
| 1926 | Toledo .....                     | 903     |                     |                     | 120                          | 83                          | 1125  |
| 1927 | Columbus .....                   | 1320    |                     |                     | 286                          | 82                          | 1705  |
| 1928 | Cincinnati .....                 | 916     |                     |                     | 92                           | 80                          | 1115  |
| 1929 | Cleveland .....                  | 1231    |                     |                     | 249                          | 124                         | 1619  |
| 1930 | Columbus .....                   | 1241    |                     |                     | 435                          | 86                          | 1775  |
| 1931 | Toledo .....                     | 826     |                     |                     | 198                          | 50                          | 1087  |
| 1932 | Dayton .....                     | 978     |                     |                     | 201                          | 45                          | 1226  |
| 1933 | Akron .....                      | 858     |                     |                     | 160                          | 25                          | 1049  |
| 1934 | Columbus .....                   | 1069    |                     |                     | 410                          | 51                          | 1539  |
| 1935 | Cincinnati .....                 | 973     |                     |                     | 197                          | 84                          | 1271  |
| 1936 | Cleveland .....                  | 1099    |                     |                     | 563                          | 137                         | 1818  |
| 1937 | Dayton .....                     | 1103    |                     |                     | 366                          | 64                          | 1551  |
| 1938 | Columbus .....                   | 1330    |                     |                     | 619                          | 104                         | 2068  |
| 1939 | Toledo .....                     | 1056    |                     |                     | 271                          | 84                          | 1426  |
| 1940 | Cincinnati .....                 | 1126    |                     |                     | 323                          | 114                         | 1589  |
| 1941 | Cleveland—Joint Meeting with AMA |         |                     |                     |                              |                             |       |
| 1942 | Columbus .....                   | 1221    |                     |                     | 527                          | 119                         | 1880  |
| 1943 | Columbus .....                   | 544     |                     |                     | 160                          |                             | 717   |
| 1944 | Columbus .....                   | 830     |                     |                     | 411                          | 130                         | 1421  |
| 1945 | No Meeting                       |         |                     |                     |                              |                             |       |
| 1946 | Columbus .....                   | 1262    | 130                 | 65                  | 507                          | 157                         | 2121  |
| 1947 | Cleveland .....                  | 1502    | 158                 | 15                  | 411                          | 328                         | 2414  |
| 1948 | Cincinnati .....                 | 1362    | 293                 | 27                  | 491                          | 214                         | 2387  |
| 1949 | Columbus .....                   | 1533    | 162                 | 221                 | 462                          | 230                         | 2608  |
| 1950 | Cleveland .....                  | 1587    | 260                 | 102                 | 707                          | 376                         | 3032  |
| 1951 | Cincinnati .....                 | 1208    | 162                 | 185                 | 647                          | 352                         | 2554  |
| 1952 | Cleveland .....                  | 1366    | 204                 | 49                  | 687                          | 395                         | 2701  |
| 1953 | Cincinnati .....                 | 1155    | 180                 | 224                 | 578                          | 298                         | 2435  |
| 1954 | Columbus .....                   | 1222    | 197                 | 173                 | 701                          | 252                         | 2545  |
| 1955 | Cincinnati .....                 | 1360    | 211                 | 185                 | 738                          | 317                         | 2810  |
| 1956 | Cleveland .....                  | 1601    | 338                 | 120                 | 1029                         | 489                         | 3577  |
| 1957 | Columbus .....                   | 1164    | 149                 | 320                 | 689                          | 368                         | 2690  |
| 1958 | Cincinnati .....                 | 1327    | 164                 | 45                  | 674                          | 325                         | 2535  |
| 1959 | Columbus .....                   | 1359    | 293                 | 445                 | 721                          | 364                         | 3182  |
| 1960 | Cleveland .....                  | 1642    | 489                 | 48                  | 1026                         | 447                         | 3652  |
| 1961 | Cincinnati .....                 | 1256    | 231                 | 24                  | 751                          | 301                         | 2563  |
| 1962 | Columbus .....                   | 1304    | 265                 | 343                 | 736                          | 371                         | 3019  |
| 1963 | Cleveland .....                  | 1502    | 336                 | 19                  | 893                          | 441                         | 3191  |
| 1964 | Columbus .....                   | 1428    | 332                 | 297                 | 1002                         | 376                         | 3435  |
| 1965 | Columbus .....                   | 1330    | 275                 | 335                 | 968                          | 394                         | 3302  |
| 1966 | Cleveland .....                  | 1484    | 309                 | 22                  | 865                          | 355                         | 3035  |
| 1967 | Columbus .....                   | 1327    | 286                 | 394                 | 1178                         | 405                         | 3590  |
| 1968 | Cincinnati .....                 | 1300    | 230                 | 35                  | 1287                         | 613                         | 3465  |
| 1969 | Columbus .....                   | 1344    | 219                 | 208                 | 1780                         | 518                         | 4069  |
| 1970 | Columbus .....                   | 1160    | 189                 | 224                 | 1355                         | 477                         | 3405  |
| 1971 | Columbus .....                   | 1049    | 159                 | 182                 | 1116                         | 451                         | 2957  |
| 1972 | Cincinnati .....                 | 1118    | 204                 | 37                  | 1172                         | 498                         | 3029  |
| 1973 | Columbus .....                   | 1100    | 130                 | 93                  | 1260                         | 431                         | 3014  |



# Woman's Auxiliary Report

## Highlights of Activities Presented Before the OSMA House of Delegates in Columbus

By MRS. LOUIS LORIA, 1972-1973 President,  
Woman's Auxiliary to OSMA

WHEN MAKING PLANS early last spring for this year, I asked Dr. Schultz what he would like the Auxiliary to do this year. He suggested two things: (1) A Speaker's Bureau to "Up the Doctor's Image" and help toward better community health, and (2) Work in the legislative area.

Accordingly, in cooperation with and financed by OSMA, plans were formed during the summer for a training session which was held in September. Twenty-five women participated in this excellent training. Brochures were made and material for speeches given to each participant. These brochures were then distributed through the counties to lay groups. The speakers have been used to a fair extent and we hope to achieve even more success next year. New programs have been made up and printed, and, by giving them out this spring, we hope the community groups will use them in the coming year's programs. We appreciate your cooperation and financing.

Legislativewise we have set up LEGSline (Legislative Effort Group System). I prefer to think of it as Legislative Emergency Go Signal, because this enables us to quickly get a message to county members from National or State concerning proposed legislation. Again with the cooperation of OSMA, a day was set up at the Legislature with 18 women attending. We appreciate Dave Rader's help. Because of a contact made that day we were able to have an Auxiliary member appointed to the Governor's Health Task Force.

Many counties have had programs on legislation. We've promoted Harry Schwartz's book, *The Case for American Medicine: A Realistic Look at Our Health Care System*. We learned about the various NHI proposals, PSRO, and took part in the LEGSline alert about HMO's. I think Auxilians are more aware and alert legislatively than ever before. We feel that even more interest and knowledge could be had if our county legislative chairmen could participate in your district legislative meetings. Many of us have the time that

you Doctors do not have to actively work in politics and, believe me, your wives are very capable. I've found this to be true as I've traveled in the counties.



Mrs. Louis Loria addresses the House of Delegates.

My theme this year was "Improving the Quality of Life Through Health Education." An amazing amount of work has been done in the recruitment of allied health personnel. Approximately \$3,000 in loans and \$30,000 in scholarships have been given to nurses, premed and paramedical students. Approximately \$96,000 has been given to AMA-ERF in Ohio and roughly half of that was raised by Auxilians. We have collected your unused pharmaceuticals, books, instruments, magazines, tape recordings and have made certain types of clothing to send to needy areas both overseas and in this country. Much has been done for Health Education in the area of VD, drug abuse, smoking, safety (including a

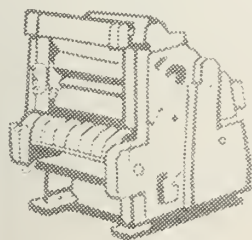
## AUXILIARY REPORT (Contd.)

good slide presentation on lawn mower safety), and nutrition. And I don't have to tell you how much volunteer community work your wives do!

At least seven counties have activities honoring Doctors — you, our husbands. I know some men object to a Doctor's Day, but March 30'th was proclaimed National Doctor's Day in 1954 by the President of the U.S. If done in a tasteful restrained way we as your wives want to proclaim to you how great you are as individuals, giving of yourselves in service to your fellowman. I wrote a short article in the March OSMA Journal as a tribute to you on Doctor's Day. I said in essence that we your wives and your children, knowing

the demands medicine makes on you, try always to graciously accept and live with these demands. We don't always succeed! We live with you and love you as you are. Your patients love you because of your ministering to them and so often put you on a pedestal. If we sometimes topple you off and bring you back to earth, forgive us for these things and love us for what we are.

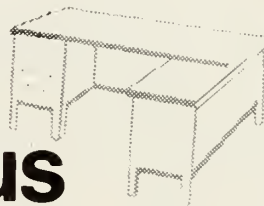
And in conclusion, in my travels over the state I've met many women. I'm awed by the tremendous amount of talent, ability and energy that these women have, **your wives**. Let us know and share in the problems, the activities, and advancements of your association. Use us when possible — we often have the time that you don't have.



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# Proceedings of The Council

Meeting of May 10, 1973

**T**HE COUNCIL met at 8:30 a.m., on Thursday, May 10, 1973, at the Sheraton-Columbus Motor Hotel, Columbus, at the close of the 1973 Annual Meeting of the Association. All members of the Council were present, except Drs. Stephen P. Hogg, Cincinnati, and Robert G. Thomas Elyria. Also present were: Dr. Richard E. Hartle, Lancaster, the newly elected Councilor of the Eighth District; Dr. John H. Budd, Cleveland, AMA Board of Trustees; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel, and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Mrs. Wisse, Mr. Moore and Mrs. Dodson, of the headquarters' office staff.

## Thanks Expressed

President Clarke thanked the members of the staff for their efficiency in carrying out Annual Meeting assignments.

## Committee on Medical Care in Jails and Prisons

The president announced the formation of the Committee on Medical Care in Jails and Prisons and asked for suggestions from the Councilors for members to serve in this capacity.

## Optometry Court Case

Mr. Pohlman discussed a court case involving the illegal practice of optometry which has an effect upon enforcement of the Medical Practice Act. The case is being appealed by the Attorney General for reversal. The Council voted to enter the case *amicus curiae* at the discretion of Mr. Pohlman.

## Committee Appointments Approved

The Council **ratified** the President's appointments to Special Committees for 1973-1974, with some minor amendments. (See this issue of *The Ohio State Medical Journal*, page 553 for the personnel of these committees.) It was voted to eliminate the Ohio State Medical Association Liaison Committee with Ohio Department of Public Welfare and use the Government Medical Care Committee for this purpose.

## Auditing and Appropriations

The Council **approved** the recommendation of the Committee on Auditing and Appropriations that a specific computerized membership system be implemented and the following resolution was thereupon adopted:

"BE IT RESOLVED, that the President-Elect of the Ohio State Medical Association be authorized to execute a contract, in form approved by legal counsel, in accordance with instructions outlined in the request for bid (Proposed Computerized Membership System Ohio State Medical Association—revised March 22, 1973) with The Republic Corporation, the terms and conditions of which shall, *inter alia*, including a conversion and implementation cost not to exceed \$9,282.00."

## HMO's

The Council **approved** a position paper on Health Maintenance Organizations, which reads as follows:


"The term 'Health Maintenance Organization' was derived by and from political expediency. It is a confusing term since there is a vast difference between the word 'health' as it is influenced by various life styles, accidents, and related problems in the environment in which we live, versus the word 'medical care.' In these issues, one often confuses socioeconomic problems with health and medical care (and lumps these problems into a conglomerate mass).

"A 'health maintenance organization' is a system for payment for services on a capitation and prepayment basis. The actual health services continue to be delivered or provided by individual physicians who, in the case of the 'health maintenance organization,' have elected to provide services on a prepaid, capitation plan.

"If HMO's are to be evaluated honestly and accurately, they should not be brought into being or maintained under the artificial stimulation of tax dollars. HMO's should be required to be self-starting on the same basis as present, self-sustaining, successful systems of medical care delivery, such as solo practice, partnership, group practice and prepaid group practice.

"In view of the epidemic over-indulgence of Americans in their eating, smoking and drinking  
(Continued on page 574)





The diabetic  
who has  
too much...

too much sugar,  
too much fat.

Maybe the last thing she needs is more of her own insulin. Especially when you consider that many overweight diabetics already have normal or high levels of endogenous insulin and that insulin is lipogenic.

If she just won't diet and oral therapy is indicated in adult-onset, nonketotic diabetes...

**DBI-TD<sup>®</sup> Geigy**  
phenformin HCl

lowers blood sugar without raising  
blood insulin.

For complete details, including dosage,  
please read the prescribing information.  
It's summarized below.

**DBI-TD<sup>®</sup> phenformin HCl**  
tablets of 25 mg.  
**DBI-TD<sup>®</sup> phenformin HCl**  
Oral-Disintegration  
tablets of 50 and 100 mg.

**Indications:** Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

**Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); surgery or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); other disease states associated with hypoxemia.

**Warnings:** Use during pregnancy is to be avoided.

**Precautions:** 1. **Starvation Ketosis:** This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively

normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**

2. **Lactic Acidosis:** This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. **Hypoglycemia:** Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

**Adverse Reactions:** Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
Ardsley, New York 10502



# What should a medication for sleep be expected to provide?



**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or

recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years

of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated patients, initial dosage should be limited to 15 mg to preclude oversedation, dizziness, or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with

## Sleep for 7 to 8 hours without need to repeat dosage during the night

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.

## Sleep with consistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration. Thus there is little likelihood for the need to increase dosage to maintain therapeutic effect.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

## Sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane; no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights. Dalmane is generally well tolerated and morning "hang-over" is relatively infrequent. Dizziness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in elderly and debilitated patients. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

# DALMANE<sup>®</sup>

(flurazepam HCl)

## When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage  
(15 mg may suffice in some patients).

One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

ROCHE

ROCHE LABORATORIES  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110

depression or suicidal tendencies. tic blood counts and liver and kidney tests are advised during therapy. Observe usual precautions in presence of impaired renal or liver function.

**Side Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia, falling have occurred, particularly in elderly or debilitated patients. Severe drowsiness, lethargy, disorientation and possibly indicative of drug intolerance or overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech,

confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.  
**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients.  
*Elderly or debilitated patients:* 15 mg initially until response is determined.  
**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



# Opinion & Dialogue

## "Prescription drugs – who should determine the maker?"

### Dispenser of Medicine

Clifton J. Latiolais  
President  
American  
Pharmaceutical  
Association



### Maker of Medicine

C. Joseph Stetler  
President  
Pharmaceutical  
Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

#### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MDs have given the impression they are not particularly concerned with the increase in cost of health care to the patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

#### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

#### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 2

ould be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

#### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

#### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

#### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

#### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

#### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

#### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005





habits, plus their aversion to walking and to adequate exercise, only a drastic change in those habits would enable 'health maintenance.'

"Tax dollars should, therefore, be devoted to improvement in the many other aspects of American life requiring support, such as improved housing, education and environmental factors, rather than in the artificial stimulation of the theoretical and, as yet, unproved concept of 'health maintenance organizations.'

"The Ohio State Medical Association supports the need for experimentation with various forms of health care delivery and encourages a fair evaluation of the performance of the various systems.

"The experimental HMO activities being fostered by the federal government should be carefully observed and their performance documented, both scientifically and fiscally, in order that a true comparison of costs and effectiveness of the various systems of health care delivery are available for critical evaluation and appropriate action."

#### Life Membership Committee

In connection with the adoption of Resolution No. 56-73, establishing a category of Life Membership, the president appointed the following committee to implement this resolution: James L. Henry, Chairman; Maurice F. Lieber, and Robert E. Rinderknecht.

#### 1974 Annual Meeting

Dates for the 1974 Annual Meeting, in Cleveland, Ohio, were established as *Sunday, May 12* through *Wednesday, May 15*. The first session of the House of Delegates is to be held on Sunday evening, and the final session is to be held on Wednesday.

It was decided to have all exhibits open from 9:00 a.m. to 4:30 p.m., Tuesday, May 14 and Wednesday, May 15.

#### Greenbrier Meeting

The Council authorized a September meeting (September 28-30), at The Greenbrier in West Virginia.

Other Council dates were established as follows: *July 14-15; November 3-4; December 15-16, and January 25-27, 1974.*

#### Commission on Education

The Council approved a proposal that a representative of the American Medical Association be invited to meet with the Commission on Education with regard to the AMA services available to reinforce the Ohio State Medical Association Continuing Education Program.

The Council then adjourned.

ATTEST: Hart F. Page  
Executive Director



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# Woman's Auxiliary Highlights

## Report on the 1973 Annual Meeting

### Woman's Auxiliary to the OSMA, Cincinnati

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

THIS YEAR OF 1973 witnessed the thirty-third annual convention of the Woman's Auxiliary to the Ohio State Medical Association. It took place on May 7, 8 and 9 and the scene of activity was the Christopher Inn in Columbus. Mrs. Louis Loria, 1972-73 president, chose as her convention theme "Open A New Door."

I couldn't help but ruminate about the contrasts in time—the world as we knew it in 1940 when Ohio's Auxiliary came into being, and the world in which we live today. Thirty-three years ago, who would have really believed that man would land on the moon? Who (other than the scientists feverishly at work) would have really believed that some five years later there would be an atom bomb that would trigger destruction of unbelievable magnitude? Television? Organ transplants? The Pill? Women construction workers? In 1940, words of magic possibly, but certainly not of reality!

Many doors have been opened since that first year of Auxiliary—sociologically, medically, economically, scientifically and technologically. Yet there is always another door to be opened by dedicated doctors' wives whose organization has grown with the years into an ever richer maturity. Always the standard bearer must be "Open A New Door."

That was the awareness that pervaded as the gavel sounded the opening of the first business session of the thirty-third annual convention on Tuesday, May 8 at 9 a.m. at the Christopher Inn in Columbus, and presided over by Mrs. Loria, president. The invocation was given by Mrs. H. R. Hunt, of Trumbull County, which had been written by Mrs. B. E. Goodman, also of Trumbull. It was an especially warm and moving invocation, "tailored" for the doctor's wife.

The pledge of allegiance was led by Mrs. William Crawford, Butler County, and the pledge of loyalty by Mrs. W. F. Stevenson, Columbiana County. Mrs. Floyd Beman, president, Franklin County, extended greetings and a warm welcome to the delegates, members and out of state guests.

Dr. William R. Schultz, President, OSMA, urged the auxiliary to continue its Speakers' Bureau activity to help with the "Up With Medicine" aims of the doctors. "We can help change the direction of thinking in this country," said Dr. Schultz as he urged the auxiliary to keep pushing forward for medicine's sake. The OSMA president warmly greeted the House of Delegates and acknowledged with thanks the outstanding contributions made by the auxiliary.

Mrs. Malachi W. Sloan, II, state past president and North Central Regional legislation chairman, introduced these out of state guests: Mrs. Robert Beckley, president, national auxiliary; Mrs. John H. Eves, president, Pennsylvania; Mrs. Frederick Gilmore, president-elect, Pennsylvania; Mrs. Robert Hartman, president, Illinois; Mrs. Philip Smith, immediate past president, Indiana; Mrs. Willis Stogsdill, president, Indiana; Mrs. Barbour Fleming, president, Michigan; and Mrs. William J. Jones, president-elect, Michigan.

Mrs. Loria then introduced her two convention chairmen: Mrs. Paul S. Metzger and Mrs. Donald L. Lewis. These are the two women from Franklin County who spearheaded this year's convention with zest, enthusiasm and dedication. Along with their advisor, Mrs. Floyd Beman, and their innumerable hard-working committees, these women made possible a smooth-running, efficient and happy convention. Thank you much, Franklin County.

The traditional "early bird" prizes were drawn and presented by Mrs. H. W. Davis, Delaware County. Roll Call report by Mrs. Dale Dickens, Franklin County, revealed an attendance of 108, with a quorum established.

#### National President

Mrs. Robert Beckley, president of the Woman's Auxiliary to the American Medical Association, was introduced by Mrs. Armin Melior, Scioto County. Mrs. Beckley has visited three Ohio conventions—first, as president of the Pennsylvania



auxiliary; second, as treasurer of the national auxiliary; and this third time as national president.

"We should be committed to helping our husbands," she said, "in effect, building the bridge for them." She went on to discuss what she called the three challenges in building that bridge: First, strength and unity in the profession; second, becoming involved in health education in the schools; and third, educating the public generally about the medical profession.

Mrs. Beckley talked of the \$740,388 given last year by the auxiliaries for AMA-ERF and the \$654,889 contributed in scholarships and loans for paramedical careers, making a total of \$1,395,278 for the year 1972. The national president said there are 90,000 auxiliary members in the United States and 1,200 organized counties. She added that she was indeed happy to announce that at long last New York City has become organized as an auxiliary. She urged that good fellowship be encouraged among physicians' families and that no auxiliary should apologize for its social activities. Mrs. Beckley, in discussing the various auxiliary activities, announced that the 1973-74 year would also focus on the battered child syndrome and alcohol on the highways.

### Mrs. Loria's Report

The detailed report of Mrs. Louis Loria, 1972-73 president, will be found elsewhere in this issue. This is the report of Ohio's auxiliary as it was presented to the House of Delegates of the Ohio State Medical Association. Here I highlight just a few of the remarks our state president made before our own House of Delegates: "You, as counties, have done the work," said Mrs. Loria as she discussed such outstanding activities as the Speakers' Bureau, the LEGS program, the Health Manpower survey, Doctors' Day observance in the counties, and AMA-ERF. "Some \$29,000 was offered in Health Manpower loans," she pointed out, "with over \$2500 in outright gifts." She spoke of the International Health program and the 18,000 pounds of drugs and equipment sent to World Medical Relief. Eileen Loria's year of further emphasis on health education, community service, legislation and nutrition paid off in dividends of accomplishment. In this past year's workbook, Mrs. Loria used a quotation from Oliver Wendell Holmes which sums it all up neatly: "The great thing in this world is not so much where we stand as it is in what direction we are moving". . . .

### Nominative Slate

Mrs. Russell Wiessinger, immediate past president and chairman of the Nominating Committee, presented her committee's recommended 1973-74 slate of officers who were subsequently elected by

voice vote: President-elect, Mrs. S. J. Glueck, Clark; first vice-president, Mrs. Howard E. Smith, Lucas; second vice-president, Mrs. Henry Holden, Mahoning; third vice-president, Mrs. Albert May, Marion; recording secretary, Mrs. Paul Chrenka, Cuyahoga; corresponding secretary, Mrs. Carl F. Goll, Jefferson; treasurer, Mrs. William Myers, Pickaway. Directors-at-large to serve two years: Mrs. Emil L. Barrows, Hamilton; Mrs. Donald Dewald, Richland; Mrs. Thomas L. Manning, Cuyahoga. Director-at-large to serve one year: Mrs. Robert Holladay, Allen (to finish the term of Mrs. Myers who became treasurer). District directors: First—Mrs. Charles Blase, Hamilton; Third—Mrs. Emeliano Feliciano, Mercer; Fifth—Mrs. Wesley Pignolet, Lake; Seventh—Mrs. David Creamer, Belmont; Ninth—Mrs. B. U. Howland, Scioto; Eleventh—Mrs. John Emery, Huron.

Mrs. Wiessinger then presented the names for the 1973-74 Nominating Committee: four from the Board, two of whom are to be elected; ten from the general membership, five of whom are to be elected. As there were no nominations from the floor, Mrs. Loria announced that the election for the 1973-74 Nominating Committee would be by ballot at the designated voting hours that afternoon.

The President then called for nominations for delegates and alternates to the convention of the Woman's Auxiliary to the American Medical Association to be held in New York City June 24-28. Twenty-three such names were placed in nomination. Instructions for voting were then detailed by Mrs. Edward L. Doermann, Lucas, parliamentarian.

### AMA Speaker—Dr. Ellis

Effie Ellis, M.D., keynote speaker, who is the AMA's Special Assistant for Health Services, was introduced by Mrs. Armin Melior, Scioto County. "She is no stranger to Ohio," Mrs. Melior said. "Prior to joining the American Medical Association, Dr. Ellis was director of Maternal and Child Health for the Ohio State Department of Health. During her career, she has served and is serving on numerous distinguished committees and boards for health and social agencies on regional and federal levels". . . .

The "theme" of Dr. Ellis' talk was "Quality of Life," and it was a forceful, knowledgeable and thought-provoking talk. "Over and above the technical aspects on delivery of health care," said Dr. Ellis, "must come the message loud and clear that physicians **do** care. And when we speak of Quality of Life, we must raise the level of awareness to such important facts as having to begin before one is even conceived, if we are to embark on an intelligent course of prevention.

"Quality of Life begins with the birth of his—the **baby's**—parents. What you do in one stage



affects what happens in every other stage—not only where physical well-being is concerned but in the social and emotional growth at the same time.” Dr. Ellis spoke of dividing life into three major phases—between conception and adolescence; middle years; aging years. “As we go through life,” commented the AMA speaker, “we pass through many environments . . . there is the need of social services designed for everyone, both poor and affluent alike. . . .”

Dr. Ellis spoke of her visit to China last Fall and the attitude of the Chinese toward their children. The Chinese recognize that the children are the future of their country and they nurture them like hothouse plants. “Our children are the future ambassadors and negotiators with other countries,” she reminded her audience. “We have the greatest country in the world, and we must try to keep it that way.” Dr. Ellis closed her talk with “recommit yourselves to improving the Quality of Life . . . show the world we care” . . .

Later, I asked Dr. Ellis what she considered the single most important part of the Quality of Life program. Her immediate answer: “the baby in the womb.”

### In Memoriam

A simple, impressive Memorial Service was conducted by Mrs. Russell Wiessinger, Allen County, immediate past president. She spoke of the ceremony of graduation at the end of each school year and likened it to the “meeting at the end of our auxiliary year to observe a similar ceremony of graduation . . . twenty-six of our colleagues have finished their courses and have graduated from earthly concerns to eternal life.” Mrs. Wiessinger described these women, and the others who had preceded them, as those who “have shown us the way, who have given us the incentive and challenge and who have made us proud to be a part of this great organization with its far-reaching programs . . . the past is behind us and nothing we can do will affect it. The future is before us and everything we do will affect it.”

The first business meeting recessed at 11:35 a.m.

Immediately following, there was a mad scramble for the Sheraton-Columbus Hotel and the OMPAC luncheon.

### Mark Russell

“This inside-Washington comedian without an equal” is a past master at creating what is inelegantly known as the “belly laugh.” As one commentator put it—“you don’t feel you’ve been enlightened by Mark but you know you’ve been entertained.” Mr. Russell in his “Politics Are A

Laughing Matter” took “them” all on—the big people, the establishment people and their big institutions. He spared no one and he said his things well and he not only said them but he even sang them and rhymed them! He is a satirist par excellence and he turns his satire into hilarity.

OMPAC was “heard,” of course, and its importance emphasized yet again. As it should be. As it must be. But Mr. Russell’s prescription for laughter proved a terrific tonic for the doctor and the doctor’s lady. . . .

### Workshop Session

On Monday afternoon, there had been, for the first time in auxiliary convention history, a Leadership Conference for the state board, and for county presidents and presidents-elect for 1973-74, conducted by the dynamic Mrs. S. B. Pfahl, Erie County. Then Mrs. Edward L. Doermann had taken on that Waterloo of most presiding officers—parliamentary procedure (at least it always seemed to be my Waterloo!) Mrs. Doermann, an able parliamentarian, involved the group with a “true or false” Parliamentary Pepper-Upper. Mrs. Pfahl included in her presentation such provocative discussions as How Good A Listener Are You?; An Outline for Group Decision Making; Specific Procedures for Brainstorming; Some Problems and Suggested Solutions In Critical Thinking; and The Role of the Leader.

The Tuesday, May 8, afternoon Workshop Session hit at the specifics of AMA-ERF (with Mrs. Henry Holden, chairman); Legislation (with Mrs. Malachi W. Sloan and Mrs. Pfahl); Health Manpower (with Mrs. Jack Weiland and Mrs. Ernest Fox); Health Education (with Mrs. Armin Melior); Health Services (with Mrs. Albert May); Program Development (with Mrs. S. J. Glueck); Safety (with Mrs. F. M. Freimann and Mrs. Donald Dewald).

### President’s Breakfast

Wednesday, May 9 started mighty early! Would you believe 7:30 a.m.? Yet there was a terrific turn-out for Eileen Loria’s Breakfast and the County Reports—but this time in skit form. With the ingenuity and talents of Mrs. J. Paul Sauvageot at work (Ludel Sauvageot, Summit County, is editor of *MD’s Wife*) the skit presentation was one of the most effective yet devised with which to dramatize the outstanding projects of the county auxiliaries.

The large posters were beautifully done (I suspect by the very fine artist in Ludel’s office) and each county carried out its particular endeavor in most effective fashion. What struck me the most in viewing the efforts of the different counties was the wide diversity of activities—each

of such importance in the medical picture—in which the various groups engage. There couldn't have been a more effective eye-opener for early in the morning!

### Second Business Session

The second business session was called to order by the President at 9:55 a.m. Dr. Oscar W. Clarke, incoming president of the Ohio State Medical Association, addressed the auxiliary House of Delegates in that very special, engaging way he has of speaking. If I sound a bit "prejudiced," well, I am. He has always been a particular friend of the auxiliary, serving for a number of years on the OSMA Advisory Committee to our organization. When I was state president, Dr. Clarke was chairman of that committee and I shall never forget his cooperation and interest, and his willingness to help in any way he could. And he did—often!

In his talk this May 9 morning, he promised to keep the auxiliary informed as much as possible. "Help with our profile," he asked the auxiliary. "I don't like the word 'image.' There is so much the public doesn't know." Dr. Clarke suggested that the auxiliary help to establish the true profile of the physician on the county level, that the auxiliary continue with the Speakers' Bureau which came into being this 1972-73 year, that the auxiliary continue its LEGS effort, that each doctor's wife read Harry Schwartz's book "The Case for American Medicine." "Read that book for your own sakes," Dr. Clarke said.

If there are OSMA district meetings this '73-'74 year, Dr. Clarke promised that the county legislation chairman would be invited so that she could be kept thoroughly informed. He said we must show more concern over alcoholism in youth, citing this state of Michigan example: Since the legal drinking age was lowered there to eighteen years—the accident rate in that age group has risen three hundred percent!

The new OSMA president made two other suggestions: "Re-name 'Doctor's Day' to 'Doctor's Recognition Day' and be your doctor's critic at home . . . he may not like it, but he needs it!"

The Roll Call report of Mrs. Dale Dickens revealed 207 registered. It was established that a quorum was present. Mrs. T. A. Russell, Trumbull County, resolutions chairman, presented the Courtesy Resolution of her committee. The House of Delegates voted its adoption.

### AMA-ERF Awards

Mrs. Henry Holden, Mahoning County, State AMA-ERF chairman, presented these awards: To Hamilton County for the largest contribution in the state (\$6,756.19); to Montgomery County

for the greatest increase over the preceding year (an increase of \$2,475, making a total contribution of \$4,960.27); and to Butler County for the largest increase per capita (from \$30 to \$34 per member). Mrs. Holden announced that as of convention, \$95,486.49 had been contributed to AMA-ERF this 1972-73 year, a \$22,000 increase over last year. The total figure will undoubtedly be higher by the time the final results are in for National Convention. A twenty-gun salute to Velma Holden and state AMA-ERF treasurer, Mrs. R. A. Wiltsie!

### OMPAC Chairman

The chairman of the OMPAC Board, Dr. H. William Porterfield, told auxiliary members that "OMPAC needs your help, gals—get behind us—it's a new ball game in politics and we want you to join the game—the name of the game is MONEY, helping the candidates, using the money where it is most effective—supporting the free practice of medicine". . . .

Dr. Porterfield spoke of "candidate development" at the grass roots level. He explained that the PAC's number one role in off years is raising funds that can be tucked into the bank for the next year when it is needed. He reminded the House of Delegates that PAC's concept is to provide support for those who are supporting medicine, and it is definitely nonpartisan. He urged the doctors' wives to become members on their own. Dr. Porterfield was asked if an auxiliary group membership were possible. He said that something could probably be worked out along those lines.

### New Business

Mrs. Joseph Tomashefski, Cuyahoga, state finance chairman, presented the 1973-74 budget. It was moved that the budget be adopted. Motion passed. The report of the election and tellers committee was given by Mrs. Karl Wieneke, Mahoning, who announced the results of the previous day's balloting: Those elected to the 1973-74 Nominating Committee from the Board—Mrs. Louis Loria, Trumbull; Mrs. Robert E. Krone, Hamilton. Those elected from the general membership: Mrs. Brooks Hurd, Franklin; Mrs. George F. Jones, Fairfield; Mrs. Ronald McLin, Montgomery; Mrs. Robert Perchan, Cuyahoga; and Mrs. W. F. Stevenson, Columbiana. Mrs. Wieneke then announced the names of the 17 elected delegates to the convention of the Woman's Auxiliary to the American Medical Association in New York.

### Installation

It was a "star-studded" installation in the capable hands of Mrs. Christopher Colombi, past



state president, Cuyahoga. Vi Colombi said she had borrowed the idea of an astrological ceremony from Mrs. William Thuss, a past national president, who had used that approach in a national installation. And so each of the officers was placed in her particular spot in the zodiac and each was told what the stars portend. Mrs. Karl Ulicny, president, is a Leo and, say the stars, she is a determined leader who will guide us well. Mrs. S. J. Glueck, president-elect, is a Capricorn who "always carries with her a pocketful of dreams." Virgo, Libra, Scorpio, Sagittarius and Pisces spotlighted the new group of officers as well. As she formally installed the 1973-74 leaders of the Ohio Auxiliary, Mrs. Colombi said: "May the stars shine brightly on you this coming year."

Mrs. Louis Loria was presented the past president's pin by Mrs. Russell Wiessinger, immediate past president, who expressed the auxiliary's deep appreciation for a job well done. Mrs. Loria, in turn, presented the president's pin and gavel to Mrs. Karl Ulicny and expressed good wishes, on behalf of the organization, for a most successful year.

### Inaugural Address

Mrs. Ulicny's opening words were a bit different: "I'm going to establish a new record for short speeches." She went on to say that through our Ohio Auxiliary she has met "the nicest people I have ever been privileged to get to know . . . auxiliary is the best thing that ever happened to me." She went on to say that the national and state auxiliaries establish guidelines for the various programs and projects, but that in the last analysis it is up to the local auxiliary to choose what it wants to do and feels it can best do. "If an auxiliary chooses to remain social, that's great too," Mrs. Ulicny commented. "Having you get together as doctors' wives is far more important than not getting together at all!"

The new president said her 1973-74 year would place emphasis on nutrition, safety, health education, health services, legislation, the battered child syndrome, public relations, AMA-ERF and health manpower. "Your State Board which is made up of really knowledgeable people stands ready to serve you," she pointed out. "Let us know what you'd like from us. I will travel any place in the State of Ohio. I will work with you and for you and that, of course, is equally true of your State Board."

Mrs. Ulicny announced a new format for Fall Conference this year. Instead of having it in one place on one day, she has divided the state into four regions, and Fall Conference will be scheduled in this fashion: October 22, Findlay; October 23, Youngstown; October 30, Dayton;

October 31, Cambridge. "We're coming to you," she explained. "We feel that if we can bring our Fall Conference closer to home so to speak, we'll get greater participation."

At the conclusion of her talk, Mrs. Ulicny presented her family: Dr. Karl Ulicny, daughters Susan and Sara, sons Michael and Karl, Jr. Also present were another son's wife, Alice, and tiny daughter, Kelly (Terry himself could not be there). She also introduced the members from her home auxiliary, Columbiana. Eileen Loria gave the new president a toy horse and buggy "to help in getting you around the state."

It was at 11:45 a.m. that Mrs. Loria declared the Thirty-third Annual Convention adjourned. Mrs. Ulicny and her incoming officers were honored at a champagne reception given by the Columbiana County auxiliary.

### "The Birds and The Bees"

That was the rather provocative designation given to the Wednesday luncheon at Christopher Inn. Guest speaker, introduced by Mrs. S. J. Glueck, president-elect, was the Reverend Robert Huff who serves as pastor of Trinity Lutheran Church in Midland, Michigan. For the past five years, he has conducted a course on marriage for married people at his church. "The Love and Cherish Course" has been open to the public. In addition, Pastor Huff does extensive marriage counseling and a great deal of speaking, lecturing and seminar work on marriage relationships.

The Reverend's opening statement was something of a bombshell: "Doctors generally have the worst marriages of any in the country . . . clergymen come in second." Pastor Huff is as dynamic a speaker as I have ever listened to and he minced no words, believe me! If he shocked us a bit from time to time, he more than impressed us all of the time and I'll wager that every wife in that room ended up by doing some soul searching!

It's impossible, of course, to repeat in its entirety the rousing talk he gave. Instead, in the interests of space, I'll give some "bits and pieces" that I thought particularly pertinent: "Even in this year of 1973, there is still confusion as to what it is to be a man or a woman . . . you must be realistic about life and must deal with maleness and femaleness and accept the fact that men and women are **not** the same! . . . when your husbands act the part of masculinity, you like them the least. . . ."

"It is the differences between man and woman that create the problems . . . and the basic difference is that the man's sex organs are on the outside and the woman's sex organs are on the inside . . . God did not create neutral

*(Continued on page 585)*



beings; He created man and woman . . . and just as the sex organs are externalized and internalized, so are the emotions . . . man tends to externalize emotionally and woman tends to internalize emotionally . . . women are more secure in their femininity; men are not so secure in their masculinity . . . therefore a man feels he has to **prove** his masculinity and so he is driven outside himself to function . . . man surrounds himself with all the phases of his life and manages to keep the phases separated, . . . woman cannot . . . men want women to be like them, keeping each phase apart from the other . . . women's phases are like marbles in a can, you juggle one and you juggle them all . . . man tends to relate to things and to functions rather than people . . . man moves from sex to love, woman from love to sex . . . man's masculinity is more vulnerable than woman's femininity . . . to men, sex is synonymous with achievement; man doesn't believe his wife loves him if he doesn't achieve . . . it is the woman who must be more compassionate, more understanding, more willing to help. . . ."

Reverend Huff's closing remarks struck at the heart of the matter: "If you accept the fact and differences of maleness and femaleness, you will not be antagonistic, but rather you will complement each other. If you support him and encourage him, you will grow together. Don't shoot him down. Tell him you think he's great." Maybe not all of us agreed with all that the speaker said, but one thing is certain: he provided a lot of food for thought! And, hopefully, some sense of direction for happier marriages. . . .

### Reflections

It just isn't possible to include in this story on convention full details. The State Board meeting on Monday, May 7 was for old and new members. The State Board luncheon at noon that day also included the 1973-74 county presidents and presidents-elect. On Tuesday afternoon, there was the Gavel Club tea (the annual get-together of the past state presidents). Both Eileen Loria and Susie Ulicny received some beautiful gifts. The favorite meeting place was the Pool Lounge Area. AMA-ERF did a brisk business in the hotel lobby. Late Tuesday afternoon featured the reception for the 1972-73 Board and county presidents and presidents-elect, courtesy of Dr. and Mrs. Loria and Dr. and Mrs. Ulicny (the men did a terrific job of "hosting.")

It was a good convention—a happy convention. It was a time for learning and for fun, for renewing old friendships and making new friendships. To steal a quote from our new president: "Auxiliary is the best thing that ever happened to me!"

## Continuing Medical Education Courses for Physicians

### July

**Urologic Outing** — Sponsored by the OSU College of Medicine, July 30 - August 1, at Atwood Lodge (between New Philadelphia and Carrollton); for details contact the Center for Continuing Medical Education, A-352 Starling Loving, 320 W. Tenth Ave., Columbus 43210.

### August

**Ohio Academy of Family Physicians Annual Scientific Assembly** — Sheraton-Columbus Motor Hotel, downtown Columbus, August 3-5. For details, contact the Academy at 4075 N. High St., Columbus 43214.

**Fifth Semiannual Short Course on Laser Safety**—Sponsored by the Medical Laser Laboratory and the office of Continuing Medical Education (CONMED) of the University of Cincinnati; August 6-10; at the University; tuition \$325; course director, R. James Rockwell, Jr., for details contact CONMED, 114 Medical College, Cincinnati 45219; phone 513/861-8000, Ext. 405.

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**(See Page 588)**

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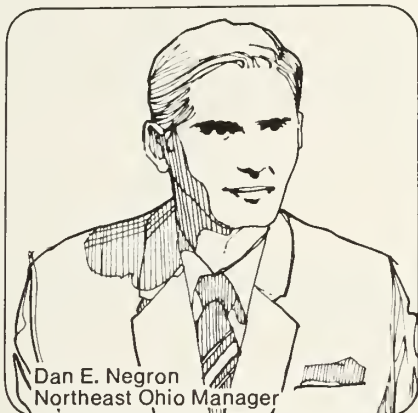
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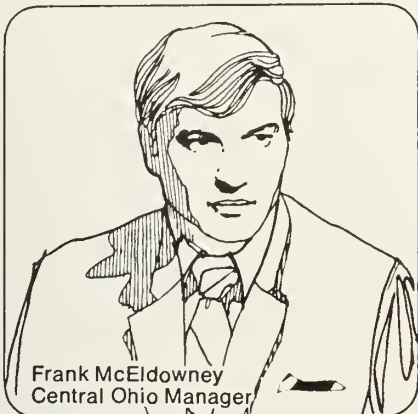
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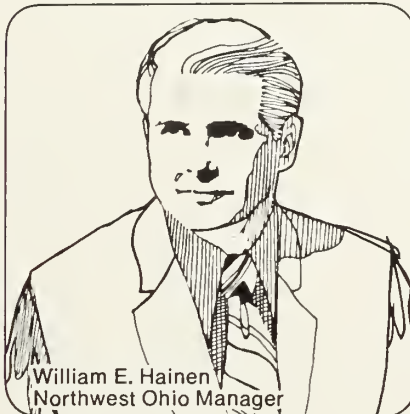
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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

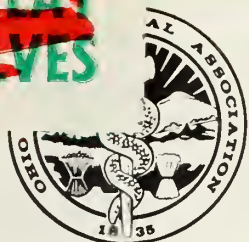
**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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VOL. 69 NO. 8

# *The Ohio State* MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

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2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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1. Gertler, M. M., et al.: Geriatrics 25:134-148 (May) 1970.

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## AMA President Honored by University of Cincinnati



Dr. Charles A. (Carl) Hoffman, right, 1972-1973 President of the American Medical Association, was guest speaker for a function of the Commencement Ceremonies of the University of Cincinnati College of Medicine and was given an honorary degree.

With him in the above picture are Dr. Robert S. Daniels, interim dean of the College of Medicine, and Russell Kridel, center, UC junior medical student and president of the Student AMA.

Dr. Hoffman was invited by the Medical College seniors to speak at their Honors Day program where he discussed the state medical care in this country and concluded his remarks by telling the seniors, "The sanctity of man as a person begins with you."

At the annual University of Cincinnati Medical Alumni Association banquet, Dr. Hoffman received the honorary degree of Doctor of Science, conferred by University President Warren Bennis. He received his M.D. degree from the University of Cincinnati in 1935.

At the commencement ceremonies, 110 seniors received their Doctor of Medicine degrees.

The American Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Convention Center in Dallas, Texas, the week of September 16-20. Further information may be obtained from Mr. Theodore Berland, 2729 W. Lunt Avenue, Chicago, Illinois 60645.



## Ground-Breaking Launches Third Building Construction for Toledo Medical College

A ground-breaking ceremony for the \$15.4 million Health Sciences Facility at the Medical College of Ohio in Toledo was held early in July, with local, state and national dignitaries attending.

College President Dr. Marion C. Anderson said the building will be the largest of the three now being built on the college's new campus.

It will contain two 250-seat lecture rooms; two 100-seat seminar rooms; eight multi-purpose teaching facilities; faculty offices and laboratories; and the college's Animal Research Facility.

It is the first of the college's buildings to receive any federal support for construction—\$4.9 million. The State of Ohio is contributing more than \$10.5 million.

The Health Sciences Facility will be one of the key resources in enabling the Medical College to reach its goal of 150 medical students, per class, by the 1980's, Dr. Anderson said. The building is expected to be completed in September, 1975.

## Ohioan Gets Mead Johnson Family Practice Award

Dr. Terry Hankey, author of a 1971 article in *The Journal* on his experiences in a community medicine preceptee program, has been named a recipient of the Mead Johnson Award for Graduate Training in Family Practice. The monetary award is given each year to ten outstanding residents in family practice.

A former resident of the Xenia area, he received his medical degree from Duke School of Medicine in 1972 after graduating magna cum laude from Wright State University.

Terry Hankey wrote the article in the February, 1971 issue of *The Journal* entitled "A Preceptee's Experience in Community Medicine," a detailed account of his reaction to a program sponsored by the Miami County Medical Society. (Please refer to February 1971 issue of *The Journal*, beginning on page 156.)

The award was announced to Dr. Hankey at St. Marys Hospital, Madison, Wisconsin, his chosen institution for his family practice residency.

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during June. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

#### CLARK

Simeon J. Palomino,  
Springfield  
Sajjad H. Siddiqi,  
Yellow Springs  
Damanjit Yakhmi,  
Springfield

STARK (Canton,  
except as noted)  
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Alliance  
Ralph A. Polumbo  
Alexis S. Sayoc  
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Albert J. Cook,  
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Akron  
Robert W. Gulmi,  
Tallmadge  
David L. Hoff,  
Tallmadge  
Suk Ho Kang,  
Cuyahoga Falls  
Chin Kyll Kim,  
Cuyahoga Falls  
Manohar Lal,  
Akron  
Alfredo L. Salcedo,  
Cuyahoga Falls  
Jack L. Summers,  
Akron  
D. Venkataramani,  
Cuyahoga Falls

#### CUYAHOGA

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Walton R. Garner  
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Steubenville  
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Rockn Jalili,  
Mansfield

#### TRUMBULL

Avutu R. Reddy,  
Warren

#### VINTON

Altat Hussain,  
McArthur

The University of Louisville School of Medicine will present its Seventh Annual Newborn Symposium on November 8-9, at the Health Sciences Center Auditorium in Louisville. For more information, write Billy F. Andrews, M.D., 226 East Chestnut Street, Louisville, Ky. 40202.

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## MDs in the News

Dr. K. D. McMurrain, Jr., medical director of the Procter and Gamble Company, Cincinnati, was named a member of the Board of Directors of the Industrial Medical Association at the organization's 58th annual meeting in Denver.

Dr. Walter A. Hoyt, Jr., Akron, was installed as president of the American Academy of Orthopaedic Surgeons at the group's recent annual meeting in Las Vegas.

Dr. Frederick C. Robbins, Dean of Case Western Reserve School of Medicine, was elected President of the 85-year-old American Pediatric Society at its annual meeting in San Francisco on May 17. Dr. Robbins, who is Professor of Pediatrics, served as Chairman of the Department of Pediatrics at Cleveland Metropolitan General Hospital for 14 years.

Dr. Robert G. Page, provost and dean of the Medical College of Ohio at Toledo, has been appointed to a four-year term on the Program Advisory Committee for general research support in the National Institutes of Health, Division of Research Resources. The committee is responsible for advising NIH's General Research and Biomedical Sciences Support Grant Programs.

## Ohio National Guard Needs Physicians in Certain Areas

The Ohio Army National Guard has need for physicians at facilities in several areas of Ohio, and personnel of the Guard would like to discuss the advantages of this type of service with doctors who may be interested.

A communication from Colonel John J. Simmons, of the Adjutant General's Department in Worthington, said that facilities at the following locations are in need of physicians: Ashtabula, Athens, Cincinnati, Cleveland, Dayton, Greensburg, Portsmouth, Toledo, Westerville, and Worthington.

Physicians interested in more information are invited to write the Adjutant General's Department, P. O. Box 660, Worthington 43085, or phone Major Robert Green at 614/889-8354; or Walter Donagh, 614/469-5926 during normal working hours. Mr. Donagh also will be glad to answer questions after normal working hours at 614/274-5806.

The American College of Physicians has announced dates and locations of 29 Regional meetings and 43 Postgraduate Courses to be held between September 1 and June 30, 1974. Additional information may be obtained by writing the American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.



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phenformin HCl

lowers blood sugar without raising  
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For complete details, including dosage,  
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It's summarized below.

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tablets of 25 mg.  
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**Contraindications:** Diabetes mellitus that can be controlled by diet alone; juvenile diabetes mellitus; diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (diabetic ketoacidosis, coma, infection, gangrene); surgery or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); severe disease states associated with hypoxemia.

**Warnings:** Use during pregnancy is to be avoided.  
**Precautions:** 1. **Starvation Ketosis:** This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of rel-

atively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**

2. **Lactic Acidosis:** This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. **Hypoglycemia:** Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

**Adverse Reactions:** Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-E (6/72)

For complete details, including dosage, please see full prescribing information.

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# Opinion & Dialogue

## "Prescription drugs – who should determine the maker?"

### Dispenser of Medicine

Clifton J. Latiolais  
President  
American  
Pharmaceutical  
Association



### Maker of Medicine

C. Joseph Stetler  
President  
Pharmaceutical  
Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

#### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MDs have given the impression they are not particularly concerned with the increase in cost of health care to the patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

#### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

#### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 2

ould be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the practices of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

for 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005





# Obituaries

**William Moorehead Ankeney, M.D.**, Dayton; Western Reserve University School of Medicine, 1918; aged 80; died June 24; member of OSMA, AMA, and the American Academy of Family Physicians; general practitioner in Dayton since 1930 and previously a medical missionary in China.

**Lothair Jay Carson, M.D.**, Cleveland; Western Reserve University School of Medicine, 1920; aged 81; died June 2; member of OSMA, AMA and American Academy of Dermatology; practitioner of long standing in Cleveland before his retirement, specializing in dermatology.

**Linus Leslie Chandler, M.D.**, Branch, Mich.; Western Reserve University School of Medicine, 1913; aged 85; died June 25 as the result of a traffic accident; member of OSMA and AMA; practicing physician and surgeon in Cleveland for many years before his retirement in 1967.

**Oscar Ray Clovis, M.D.**, Canton; Jefferson Medical College of Philadelphia, 1917; aged 81; died June 3; member of OSMA and AMA; former surgeon for the Ringling Bros. Circus, and practitioner in Canton from 1940 to the current year; past president of the Canton Medical Library; veteran of World War I.

**Florian P. Cuthbert, M.D.**, Massillon and Canal Fulton; Northwestern University Medical School, 1935; aged 65; died June 15; member of OSMA, AMA, American Proctologic Society and American Society of Abdominal Surgeons; Fellow,

American College of Surgeons; practitioner in western Stark County since 1937, early as a general practitioner and later as a specialist in proctology.

**Charles Webster Elkins, M.D.**, Tuscon, Arizona; Western Reserve University School of Medicine, 1937; aged 63; died in early June; former member of OSMA; Fellow, American College of Surgeons; diplomate, American Board of Neurological Surgery; former practitioner in Cleveland; veteran of World War II.

**Arch Dunham Harvey, M.D.**, Lebanon; University of Cincinnati College of Medicine, 1934; aged 65; died June 9; member of OSMA and AMA; practitioner of long standing in Lebanon and Warren County health commissioner for about 20 years; veteran of World War II.

**Otto Fridrich Lanka, M.D.**, New London; medical degree from the University of Latvia, 1939; aged 63; died June 25; member of OSMA, AMA, American Academy of Family Physicians, and American Society of Abdominal Surgeons; practitioner in the New London area since about 1955, specializing in general surgery and Ob-gyn.

**Thomas Livezey Laughlin, Jr., M.D.**, Cleveland; Hahnemann Medical College of Philadelphia, 1933; aged 66; died June 4; member of OSMA, AMA, and American Society of Abdominal Surgeons; Fellow, International College of Surgeons; practitioner in the Cleveland area since



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1936. His father was the late Dr. Thomas L. Laughlin, Sr., of Dayton. A brother, Dr. Victor C. Laughlin, of Cleveland, is among survivors.

**George Lyle Morris, Jr., M.D.,** Hillsboro; Temple University School of Medicine, 1946; aged 51; died June 27; member of OSMA, AMA, the American Geriatrics Society, and Aerospace Medical Association; general practitioner in the Hillsboro area for a number of years; veteran of World War II.

**Theodore Sanford Myers, M.D.,** Carroll and Columbus; Ohio State University College of Medicine, 1952; aged 54; died June 14; member of OSMA and AMA; resident of Carroll and practitioner in Carroll and Columbus; veteran of World War II.

**Maynard Smith Owen, M.D.,** Delaware; Columbia University College of Physicians and Surgeons, 1907; aged 92; died April 22; practitioner in New York for about 40 years.

**Wallace Bowles Taggart, M.D.,** Dayton; Western Reserve University School of Medicine, 1924; aged 76; died June 4; member of OSMA, AMA, and American Academy of Pediatrics; diplomate, American Board of Pediatrics; practitioner of long standing in Dayton, specializing in pediatrics, and associated with the Children's Medical Center; veteran of World War II.

The University of Miami School of Medicine, Department of Otolaryngology, is presenting a postgraduate course entitled "Otolaryngology for the Family Practitioner." The course will be held October 26-27, 1973, at the Playboy Plaza in Miami, Florida and it is accredited by the AAGP. For information write: Bruce W. Weissman, M.D., Department of Otolaryngology, University of Miami, School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Florida 33152.

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**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

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VOLUME 69

AUGUST 1973

NUMBER 8

## Lightning's Incredible Attack on American Football In 1970

SOL M. MAGGIED, M.D.

**L**IGHTNING KILLS approximately 400 persons each year in the United States. Another 1,000 or so are injured by this phenomenon of nature.

Incredibly, during a 26-day span in the fall of 1970, a total of 30 American football players, coaches, and spectators were struck by lightning on or near playing areas. There were five immediate deaths (all players), two neurologic residuals (players), and 23 concussions (two coaches, one spectator, and 20 players).

Why lightning had affinity for this relatively large number of football personnel during such a short time span in 1970 is not known.

This discussion brings many factors into consideration but does not lead to any cause-and-effect conclusions. The information is presented for whatever use it may be to team physicians, coaches, and others who deal with athletics. Perhaps the subject calls for more study and more statistical data that may lead to such conclusions and hopefully afford more protection to our youth who pursue outdoor sports.

### Case Reports\*

At Pueblo, Colorado, on August 29, 1970, D.N., a 21-year-old, white, college senior, was run-

---

*Two things most to be feared on a golf course are lightning and a short putt.\**

The hazard of standing erect in an open field during a thunderstorm is well known. In this paper, Dr. Maggied places on the record several tragic incidents that occurred in eerie sequence. With the thought that this might not have been a chance occurrence, we publish the report essentially as submitted, hoping it will remind others of a common hazard that might recur in unexpected circumstances. — *The Editor*

\*Substance of a statement attributed to Sam Snead.

---

ning a pass pattern at 3:35 PM during a light shower at which time he was knocked unconscious by a bolt of lightning. Complete cardiac arrest was forestalled by the university trainer, Fred Oglesby, using external cardiac massage for 15 minutes. Three other players nearby suffered concussion, two were unconscious for about 15 minutes, but all three recovered with no known residual.

D.N. was wearing his head gear over medium-short hair, a metal face mask, cleated football shoes, and his full uniform (light shirt). The temperature was 80 F to 85 F.

D.N. was burned extensively in the pubic and belt buckle area although he was not wearing a

---

\*Refer to Table

Submitted March 19, 1973.



TABLE 1. Facts Relating to Seven Football Players Struck by Lightning in the Fall of 1970

| Name             | D.N.                        | R.J.N.                 | M.V.W.               | A.F.             | R.J.             | D.C.              | L.V.             |
|------------------|-----------------------------|------------------------|----------------------|------------------|------------------|-------------------|------------------|
| Age              | 21                          | 17                     | 16                   | 14               | 14               | 14                | 17               |
| Location         | Pueblo, Colo.               | St. Petersburg, Fla.   | St. Petersburg, Fla. | Cleveland, Ohio  | Cleveland, Ohio  | New Concord, Ohio | Zanesville, Ohio |
| Month            | August                      | September              | September            | September        | September        | September         | September        |
| Day              | 29                          | 7                      | 7                    | 7                | 7                | 21                | 23               |
| Time             | 3:35 PM                     | 11:30 AM               | 11:30 AM             | 4 PM             | 4 PM             | 4 PM              | 6 PM             |
| Temp.            | 80-85 F                     | 90 F                   | 90 F                 | 81 F             | 81 F             | 80 F              | 76 F             |
| Weather          | Light rain                  | No rain*               | No rain*             | Shower           | Shower           | Shower            | Thundershower    |
| Apparel          | Football uniform            | Football uniform       | Football uniform     | Football uniform | Football uniform | Football uniform  | Street clothing  |
| Head             | Head gear                   | Head gear              | Head gear            | Head gear        | Head gear        | Head gear         | Bare             |
| Hair             | Medium-short                | Short                  | Short                | Long             | Long             | Medium-long       | Medium-long      |
| Facemask         | Metal                       | Plastic over metal     | Plastic over metal   | Plastic          | Metal            | Metal             | None             |
| "Blow-out"       | Pubis, left shoe            | Belt buckle, hips down | Belt buckle, head    | None             | Shoes, head gear | Head and feet†    | Right side‡      |
| Shoes            | Cleated                     | Cleated                | Cleated              | Soccer           | Cleated          | Cleated           | Sneakers         |
| Skin             | White                       | Black                  | Black                | White            | White            | White             | White            |
| Result           | Unconscious                 | Fatal                  | Fatal                | Fatal            | Fatal            | Long coma         | Fatal            |
| Residuals        | Cataracts, reduced reflexes | —                      | —                    | —                | —                | Reduced reflexes  | —                |
| Others injured   | 3                           | 8                      | 8                    | 12               | 12               | 0                 | 0                |
| Residuals—others | 0                           | 0                      | 0                    | 0                | 0                | 0                 | 0                |

\* Light shower commenced immediately after lightning struck

† Severe burns on head and feet

‡ Severe burns on right arm, right chest, right leg

belt buckle. A "blow-out" spot appeared at the left shoe.

He was unconscious nearly two days, but he could talk by the fourth day. After 2½ weeks, he returned to classes but not to football because of markedly reduced reflexes. Three weeks after the patient's discharge from the hospital, cataracts began developing in both of his eyes. Despite the lens problem, the young man returned to football during 1971 for the first six games and then was forced to quit because of "a severely pinched neck nerve," described as not related to the lightning strike. This young man was scheduled for right-eye cataract surgery at Christmastime 1971, and, if necessary, surgery to the left eye at a proper future time.

Nine days after the D.N. incident, four more U.S. athletes were killed by lightning!

On September 1, 1970, at 11:30 AM at St. Petersburg, Florida, two black, high school football players were working out in full uniform, which included plastic-over-metal face masks attached to their head gear, cleated football shoes, and shoulder pads covered by light jerseys. Both boys had short hair. The temperature was 90 F with no rain falling when the bolt struck. However, thunder was heard in the distance and a light rain began shortly after the lightning struck.

R.J.N., a 17-year-old senior, was badly burned from the hips down with what could be termed a blow-out spot at his metal belt buckle and another at both shoes which contained metal posts in the cleats. Artificial resuscitation was not successful.

Teammate M.V.W., a 16-year-old sophomore, showed burns at the metal rivets in his head gear and at his metal belt buckle with some blow-out spots in this area. Again artificial resuscitation was not successful. According to Mr. Floyd E. Lay, Executive Secretary of the Florida High School Athletic Association, five other players, two coaches, and one spectator suffered concussion. Four were rendered unconscious and were not breathing. Mouth-to-mouth resuscitation rescued these four and all eight recovered with no known residual at this time. Each of the five players wore hip pads with metal buckles, but they suffered no burns or blow-out spots.

The State of Florida's Department of Health and Rehabilitation Services has only one other record of lightning deaths to athletes and that occurred in 1967 in Pinellas County to two black males, one 16 years and one 17 years of age. Except for being uninformed, no other details were available according to V. Shands McKeithen, M.D., Secretary of the Pinellas County Medical Society.

On the same day as the St. Petersburg incident, at 4 PM in Cleveland, Ohio, two 14-year-old,

## *The Author*

• Dr. Maggied, West Jefferson, is in family practice. He is Chairman of the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association, and is Delegate from Madison County to the OSMA House of Delegates.

white freshmen were killed by lightning while working out in a light-but-increasingly-heavy shower with temperature of 81 F. Each wore a head gear over medium-long hair and each wore a complete football uniform. Information concerning belt buckles was not available.

A.F. had a plastic, double-barred face mask and was wearing a pair of soccer shoes. There were no splits, burns, or blow-out spots seen on this player.

His teammate, R.J., wore cleated, low-cut football shoes and had a metal face mask attached. The head gear was split down the middle and a second blow-out spot was seen at one shoe. Informant Royer Collins, M.D., Head, Sports Medicine Section, Cleveland Clinic, stated his investigation revealed that x-ray films of this lad's equipment showed much metal in many places.

Twelve other players and coaches suffered concussion by this bolt, but all recovered fully with no known residuals.

Fourteen days later, on September 21, 1971, at New Concord, Ohio, D.C., a 14-year-old, white freshman, in full uniform, wearing cleated football shoes and head gear with plastic face bar covering short hair, was struck by lightning as his team headed toward the locker room. A sprinkle of rain had started and the temperature was 80 F.

According to Paul A. Jones, M.D., of New Concord, Ohio, this boy was rendered unconscious with incipient cardiac arrest which responded to closed cardiac massage by a coach's wife, who was a registered nurse. The patient was unconscious for seven weeks, four of which was in intensive care. He suffered severe burns of the right arm, right chest, and right leg, but no true blow-out spot resulted. No burn was seen in the belt buckle area and he was not wearing a buckle.

As of 16 months after the incident, D.C. was learning to read and write again and was relearning old processes at a very slow pace. He is uncoordinated, irritable at times, sensitive to noise, and cannot walk or run fast.

Two days after the New Concord incident, L.V., a white, 17-year-old Zanesville, Ohio, senior,

had just showered and combed his long hair and started toward his car at 6:15 PM in a heavy downpour. He was bareheaded, wearing high-laced sneakers, T shirt, and trousers over jockey shorts. About 75 feet from the locker room, lightning struck as he ran along a concrete walk to the parking lot. The temperature was 70 F after a short drop during a very humid day.

The concrete walk exploded under his feet but a teammate 50 feet behind him was untouched. The latter ran for the coach. Despite almost immediate mouth-to-mouth resuscitation, no sign of life returned. Severe burns were found on the back of his head and his feet. No other burns were found even though he wore a metal belt buckle.

One of the ironies of this report is that L.V. formerly lived next door to D.C. in New Concord. They were playmates between 1957 and 1959. The family of L.V. moved to Zanesville, approximately 15 miles from New Concord. Despite the intervening miles, lightning struck these two friends two days apart.

### Summary

Four of the victims struck were in Colorado which has greater elevation than the areas of the other 26 victims (14 in Florida; 10 in Cleveland, Ohio; one in New Concord, Ohio; and one in Zanesville, Ohio). There was great variation of rainfall in the areas studied, varying from no rain to heavy downfall.

Six of those struck wore head gears, while one was bareheaded (long hair). Face masks seemed to play no role in any case. Time of day seems to indicate that the greatest danger is from noon till dusk.

Pigmentation of skin seems to be of no importance as no selectivity of strokes seems indicated. Length of hair was described as one long, two medium-long, one medium-short, and three short.

The only recorded instance of lightning striking football personnel on a football field in Ohio was in 1936 on the old Canton Lehman practice field. Thirty people in a huddle were struck and one player was killed outright.

The remaining players and coaches were taken to a hospital. Seventeen people including informant, retired coach James Robinson, who spent two weeks in the hospital, suffered concus-

sion. No residuals were documented although one surviving player was blasted out of his laced, high-top shoes. One other player had burned feet. No record of burns on the slain player was obtainable. Rain started after the lightning struck.

It has long been known by high-tension linemen that a wire carrying a high-voltage current creates a magnetic field around the wire. This magnetic current will cause hair to be raised by a static-electricity effect. If contact between the hair and the wire occurs, a sparking shock ensues. For this reason, electric linemen have been asked to keep their hair from extending below their hats or helmets.

The pattern of these strikes and burns, other than the head burn of D.C., indicates that items of clothing may precipitate static electricity on the surface of the body. The common denominator would be the athletic supporter rubbing pubic hair if the number of burns and blow-outs on the sides, belt buckles, pubis, and hips could be accepted.

Clothing, and metal objects in it can be pinpointed, although 23 persons from the 1970 incidents had football uniforms on while seven did not. The one player killed and the one spectator and five coaches who suffered concussion must have had some metallic articles on their bodies that would have equaled the metal of the 23 uniformed victims.

Perhaps the one pertinent point that should be considered is whether athletes should have their shoes grounded, in order to dissipate innate production of static electricity, in the manner that hospital personnel do when they enter an operating wing. The most important "first" is to get into a brick-steel building.

A parenthetic finding while studying football helmets and questioning coaches was a nonlightning statistic, that while long hair seems to play no part in lightning deaths (with the possible exception of L.V. of Zanesville, Ohio), the incidence of traumatic concussion seems greater to the player who stuffs a headful of hair into a helmet, thereby disrupting the planned transmission of forces as developed by helmet manufacturers, and eliminating most of the suspension action in the head gear.

In regard to the preceding, it still seems incredible that a 26-day span could have caused such extensive human death and injury — especially in light of no comparable record before or since the fall of 1970.



# Contact Lenses and Athletics

FRANK J. WEINSTOCK, M.D., AND JOSEPH BITONTE, B.E.E.

MANY INDIVIDUALS who have refractive errors dislike spectacles and would walk around with blurred vision if it were not for contact lenses. Some persons have corneal irregularities, such as keratoconus or corneal scars, which make it impossible to obtain adequate vision with spectacles and require the use of contact lenses.

Although there are many medical conditions requiring the use of contact lenses, over 90 percent of wearers of contact lenses do so for cosmetic purposes — they do not want to wear spectacles. This is a legitimate reason and explains why it is estimated that over eight million individuals wear contact lenses. A large proportion of these are young persons, many of whom participate in athletics. The physician dealing with patients, especially those involved with sports teams, must be knowledgeable about these magic plastic devices.

Contact lenses come in three major types: (1) scleral lenses; (2) hard corneal lenses; and (3) the newer, soft or flexible corneal lenses.

## Types of Lenses

*Scleral lenses* are specialized lenses for special cases, usually medical diseases in which corneal lenses don't work. They were introduced about 75 years ago and are considered the first contact lenses developed. The initial purpose of the lenses was for pathologic conditions primarily and visual uses secondarily.

Later, scleral lenses were also used for cosmetic reasons and for sports. Because of the large size of these lenses, with the edges fitting under the upper and lower lids, they stay in place under very adverse conditions (football, basketball, swimming,

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and other sports); but because of their large size, the lenses are, in most cases, rather uncomfortable and can be worn only for short periods of time. The short wearing period is not a disadvantage in sports, because most sports activities do not last more than two or three hours. When used in sports, the athlete often wears hard corneal lenses most of the time with the scleral lenses reserved for the limited time of sports.

*Hard Corneal Lens.* The type of contact lens most often used in the United States is currently the hard corneal lens. This clear piece of plastic measures from about 7 mm to 10 mm in size (the corneal diameter is 12 mm) and floats on the tear film of the cornea. Since the cornea has no blood vessels and derives its nutrition primarily from the oxygen of the surrounding air and from the tear film layer, the eye must adapt to the corneal lens by increasing the wearing time slowly. If a lens is worn too long (either when first put in or by a sudden increase in wearing time in an individual who has been wearing lenses) or if a lens is fit very tightly and constricts the cornea, the nutrition of the delicate cornea may be sufficiently embarrassed to cause a very painful and potentially dan-

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gerous "corneal abrasion" (more accurately called overwearing syndrome or microcystic corneal edema). Some practitioners will intentionally fit athletes with abnormally tight corneal lenses in the hope that they will not pop out of the eye as easily as otherwise. These lenses usually can only be worn for a very limited number of hours or else corneal damage may occur. Since they can't be worn all day, several problems exist. Patients may not wear them except for games, and thus they do not have the adaptation which would have been built up by wearing well-fitting lenses every day. Hard lenses normally should be worn every day and about the same length of time every day so that the individual does not lose his adaptation. In addition, the athlete may forget to remove the "athletic" lenses after a game, if there is a celebration, thus again increasing the possibility of abrasions. Abrasions commonly manifest themselves as severe pain, sensitivity to light, and tearing which shows up several hours after removing the lenses from the eyes.

If the athlete is not comfortable, he may be tearing excessively, thus interfering with his full concentration on his role in the sport of his choice. He will not be at peak efficiency and may commit errors.

Since normal fitting methods usually allow a contact lens to stay on the cornea comfortably 10 to 14 hours a day, so-called athletic corneal lenses, which are fit tight, cannot be worn full time and are generally to be condemned. However, if the athlete is wearing "athletic-type" (tight fitting) corneal lenses, he should be equipped also with normal fitting corneal lenses, which he could and should wear an appreciable number of hours each day. A player with well-fitting hard corneal lenses should always have a spare pair available for "insurance." The team should have clean water, contact lens solutions, a flashlight, and a mirror available in case a lens is lost or in case a player gets dirt (especially mud in football) in his eye while playing. A suction cup (such as the DVM contact lens remover, available from the DVM Contact Lens Company, Zanesville, Ohio) for the quick, clean removal of a lens, is a useful addition to any first aid kit.

Contact lenses cannot be worn by all individuals and are contraindicated in certain condi-

tions, such as some infections and some corneal diseases. Furthermore, some people won't or cannot tolerate contact lenses.

In contact sports, those individuals who wear spectacles should have 3-mm industrial-strength safety lenses or plastic lenses.

*Soft Flexible Contact Lenses.* The new, soft flexible contact lenses are often more comfortable and adhere to the eye much better than the hard lenses, thus making them harder to pop out during play. They are available only for myopic (near-sighted) eyes at this time and are not satisfactory for individuals with significant astigmatism or hyperopia (farsightedness), except for people who have had cataract surgery. The overwearing syndrome is much less dangerous with them so that they can be worn by players who don't want to wear them full time, and there is much less risk of difficulties. Because of the porosity of the soft lens material, no medication or solutions, other than specially provided solutions, should be used with these lenses. Damage to either the lens or the eye could occur with certain eye drops or solutions. These "soft" or "flexible" lenses need to be cleaned carefully and "sterilized" after each wearing period with a special sterilizing kit which is furnished with the lenses. (Standard hard lenses also have to be cleaned.)

At this time, no contact lenses should be worn while swimming. The hard lenses often will float off the cornea into the water, and the soft lenses may theoretically absorb chlorine and other noxious substances from the water to cause potential harm. There are indications that the soft lenses eventually may have uses in swimming and diving.

Contact lenses may provide more efficient vision in athletes if the correct type is used, and if they are fitted and worn correctly.

### Summary

Hard, soft, or scleral contact lenses may be worn by athletes who wish to avoid wearing spectacles. They must be fitted correctly and adequately cared for to avoid damage to the eyes. Each type of lens has specific indications, contraindications, and characteristics. These should be understood by individuals concerned with patients participating in sports.

# Little League Sports Programs Another Medical View

RICHARD F. SLAGER, M.D., Columbus, Ohio

LITTLE LEAGUE PROGRAMS involving pre-adolescent children in football and baseball have been the source of continuing controversy among the medical profession. Concern stems from the potential positive effects of athletic participation versus the potential for injuries to the young, growing, rapidly changing skeletal system of the preadolescent. My studies have shown evidence that I would like to share.

Although the primary thrust of the Joint Advisory Committee on Sports Medicine of the OSMA and the Ohio High School Athletic Association has been in the direction of *adolescents* in sports activities, the Committee is on record as supporting for preadolescents (Grades 1 through 6) "well-supervised sports and recreation activities." It is recognized by this group that the healthy preadolescent child requires much daily play. Children enjoy competition and will find ways of competing. They enjoy being with their friends and, since they do not yet know their achievement level or that of their friends, will include all in attendance to participate without discrimination. It has been shown that a well-supervised program will keep them off the streets.

Seldom has any activity of children gained the printed page to the extent of Little League programs. Reporters seem eager to authenticate by news releases the opinion of a professional, who often just "shoots from the hip." It seems that they never quote statistics of the general population but speak in rather vague generalities about specific

instances. Orthopedic overkill is often supplemented by great anxiousness as to the impact from a psychological standpoint of this competition on the very young.

### Baseball

As I have attended seminars and served actively as a member of the Joint Advisory Committee on Sports Medicine, I have had time to reflect. My reflections return to my youth when I participated in Little League Baseball with little or no instruction or supervision. The games were daily, and although I rotated the pitching duties, I cannot recall ever having more than a transient sore elbow. Never did I have the problem to the extent that I had to quit pitching.

Furthermore, I was not aware of any other pitcher having a disabling elbow condition. To carry it further, I have never been referred a patient with "Little League Elbow" in 13 years of active practice of orthopedic surgery. When asking my colleagues who have divergent opinions about the condition, I have been unable to talk to, examine, or evaluate a single person with the ailment.

My study further was directed to the Cub Scout Baseball Program in Upper Arlington, Ohio. The commissioner of the program stated that 7,000 boys have gone through the program and that he is not aware of one lad who had to give up pitching because of "Little League Elbow." He did state that league rules would not allow boys to throw curve balls, or pitch in excess of three innings. This latter may include 9 or 99 pitches, which also could be questioned by many.

With the interest becoming greater, I asked if the physicians of Ohio could be polled. The only response to the poll received by the OSMA was from a mother in Dayton, Ohio whose 15-year-old son had had a sore elbow. She hoped to avoid the problem in her younger son. The first boy has, however, improved to such an extent that he was

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From time to time, we shall publish essays expressing personal opinions on clinical and scientific subjects. It is to be understood that these represent the authors' personal opinions, not necessarily representing or contradicting those of *The Journal* or the Association. Contributions to this feature and letters regarding those published will be welcome, but *The Journal* will reserve the right to reject or to edit both the essays and the responses. —*The Editor*

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on a full athletic (baseball) scholarship at Eastern Kentucky University.

The other reported preadolescent cases that had pain in the area of the medial epicondyle included a young hockey player who was slapping at a puck, a third baseman who never pitched, a wrestler who fell on an outstretched arm, and a tennis player who was practicing forehand volleys at the net. Although I do not question that the condition exists, there was not one reported case in our poll from Little League Baseball as we polled the entire state of Ohio.

As an orthopedic surgeon with special interest in sports medicine, I have been allowed to examine and treat professional baseball pitchers (Columbus Jets) as well as high school and college pitchers with sore elbows. Not one of these players related that he had first had elbow pain while throwing as a youngster. All ages relate that they have pain in the elbow if they throw a great number of curve balls.

### Conclusion

1. Pitching, and particularly curve-ball pitching, is an abnormal motion that allows for sore elbows in all ages.

2. Any injury to the elbow must be self-limiting in youngsters, since no child with the problem has been eliminated from later playing baseball because of "Little League Elbow" in the Upper Arlington program or other surveyed baseball programs in Ohio.

I have been further impressed with the Little League (Cub Scout) Program in Upper Arlington. The parents are well-represented at the games, and they express to their children that they are interested and care. The children seem quite unaffected and frequently amble about with no conscious thought about their game, even looking at the play on a neighboring diamond during what, to most adults, is the heat of an excitingly tight game. It has been my impression that the boys for the most part note very little of the pressure and have even forgotten the entire incident approximately 30 minutes after the game (win or lose), and most of the boys could not recite the final score of the last game they played.

### Football

The most recent criticisms from the lay press as well as from certain physicians have been leveled at Little League Football programs. Parents, as a result, have asked questions, such as: "How stunted will he be if he plays, Doctor?" To my surprise, there are some physicians who still hold that permanent damage to young growing bones as a result of football is not only a possibility but a likely probability.

Every legitimate study has demonstrated that

serious injuries occur more frequently in the high school, college, or professional athlete with one exception and that is in the physically mismatched children such as one sees in the uninstructed football games of the side yards.

The president of the Upper Arlington Baseball and Football Association reported that 2,100 boys under the age of 13 years have been involved in their football program during the last eight years with but one injury that demanded open surgery. The boys were matched by size and age and were given excellent instruction and equipment.

It is estimated that the involvement in numbers would favor approximately four times as many boys playing Little League Football as those in the school programs. For every Little League injury, we could name 30 or 40 high school boys who have been injured. Not only is the incidence higher, but the injury is much more serious.

The support by coaching and attendance at games by the parents has been greatly maligned. When we in one breath speak of alienation and generation gap, how can one in good conscience say that the parent spectator is bad? Although there may be parents who are obnoxious, overly protective, and/or aggressive, it still is evident to me that the master effect is a very positive one. These parents are all saying: "We care, are proud, and love you."

Physicians in Temple, Texas, and Eugene, Oregon have noted that the injury ratio of participants in Little League Football, Basketball, and Baseball was quite low and equally spread between sports. However, when a child became mature or had passed puberty, at about age 15 years, the injuries in football far outdistanced all sports. It literally skyrocketed off the page. Where many physicians recommend that children not play until they are mature, I believe the statistics to prove the opposite.

### Summary

There is no evidence to support a thesis that athletic competition in preadolescent boys and girls is harmful to their physical well-being. It further is shown that the incidence of injury is more common in the adolescent or professional athlete than in the preadolescent.

We therefore suggest enthusiastic endorsement of Little League programs rather than the qualified acceptance with the constant sensationalism in the newspapers augmented by statements that are not based on fact.

We are not on the brink of annihilating our young children. Further, it is my opinion that if the public is properly informed, wise decisions will follow. Some of the material presented may be contrary to some of your present beliefs, but I suggest that you evaluate for yourselves.

# Shower Cap Technique

## An Absorbent Dressing for Draining Sinuses

VICTOR C. LAUGHLIN, M.D.

SINCE 1953, in the Department of Urology at Huron Road Hospital in Cleveland, we have, I believe, used just about every form of dressing recommended for sloppy draining wounds anywhere. Such dressings have included adhesive plastics, suction gadgets, plastic covers, "wraparounds," and others. Some results have been good and some bad, but most annoying is the dripping from beneath the dressing producing a wet patient and a wet bed.

The simple outfit herein presented is not perfect, but it is practical, cheap, easily applied by the patient and the nurse alike and, in our hands, has proved very useful.

Every hospital has shower caps for their patients' use although, normally, the patient might be expected to provide his own. In our hospital, we buy them by the gross on the open market. At the last purchase in quantity, they were 19¢ each. The other essentials to this technique are abdominal pads, and/or fluff gauze and Montgomery straps (Fig. 1). The shower caps are sterilized by one means or another, although we have not found sterilization of the caps always to be necessary.

Sterile abdominal pads or the fluff gauze are loaded into the interior of the shower cap (Fig. 2). This provides a large absorbent surface area for contact with the sinus tract to pick up the discharges. Most important is that the *concave* recesses around the interior periphery of the cap catch any drip which might otherwise, with ordinary dressings, run out from beneath the dressing. Further, this concavity has the tendency to collect

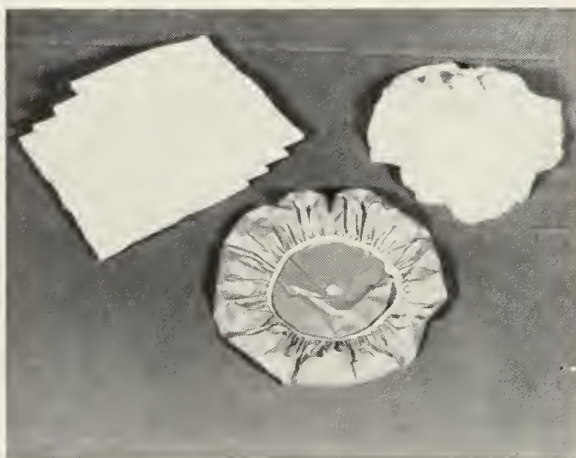


FIG. 1. Fluff gauze, shower cap, and abdominal pads.



FIG. 2. The loaded shower cap.



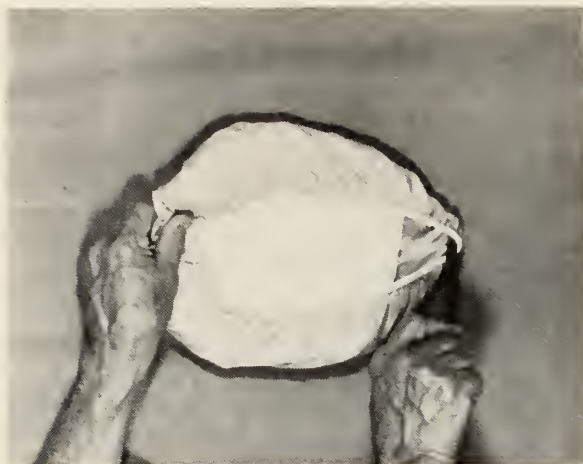


FIG. 3. Demonstration of concavity of shower cap.

such drainage and hold it long enough to allow for absorption and retention with the pads or gauze (Fig. 3).

Figure 4 demonstrates "shower cap technique" as applied to a loin sinus. In this instance, it is supported by nonallergic Montgomery straps. Figures 5, 6, and 7 demonstrate other applications. Incidentally, we like the use of the wide-band athletic supporter for added lift and security. We frequently employ such a support with an extra-wide waist band, when the technique is applied



FIG. 4. Shower cap technique applied to loin wound.

## The Author

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to upper abdominal or loin sinuses. Mobilization of the patient is thereby facilitated.

In the early weeks after prostatectomy, "shower cap technique" is especially helpful in that it provides protection for the clothing and for the upholstery when the patient gets home — an added premium very much appreciated by the homemaker and reflected in the dry cleaning bill. For this application, place the *penis and the scrotum* (both) in the prepared cap. The back edge of the cap should be placed behind the scrotum at the perineum, thereby including the entire genitalia in the dressing (Fig. 7). If this precaution is not observed, the dressing will not function efficiently. The technique also can be employed for the incontinent female, the filled cap being held in place with a perineal binder or a strong sanitary belt.

Further, we recommend that the patient wear his "shower cap" equipment even when in bed,



FIG. 5. Used as dressing for suprapubic wound.





FIG. 6. With athletic supporter for added lift and security.



FIG. 7. Used in early postoperative incontinence.

replacing or refilling the cap with absorbent material as necessary.

Our abdominal (gastrointestinal) surgeons now occasionally make use of this technique, for gallbladder and other draining sinuses, when not using more conventional measures, an added endorsement, I believe.

It now remains for us to interest one of the manufacturers of plastic medical supplies in the production of quality plastic shower caps, in appropriate colors at a proper price, so that we may have our own source of supply within the profession and no longer have to resort to purchase on the open market.

### Summary

"Shower cap technique" is a simple device of great practical value. It is prescribed for urinary incontinence in the male principally. It is also useful for urinary fistulae anywhere, in general for draining sinus tracts of other systems, and occasionally for urinary incontinence in the female.

The technique involves inexpensive, disposable plastic shower caps, abdominal pads, and/or fluff gauze, available on every floor of any hospital. The assemblage and the application of this technique have been described and illustrated.

**A** HANDWRITTEN NOTE on one of your Rx slips to the president or the director of advertising of a pharmaceutical manufacturer, we are told, might affect the amount of advertising that a company buys in our *Journal*.

Look through the ads. If one has particular appeal to you, write and tell the company so.

If you find an important company missing from the list of advertisers (see page 639), write and ask why they do not support the official publication of the Ohio State Medical Association with their advertising. —*The Editor*

# Malignant Mesenchymoma of the Mediastinum

## Report of a Case

RAYMOND G. HAWLEY, M.D., AND MYSORE S. N. MURTHY, M.D.

MESENCHYOMAS have been defined by Stout in 1948 as tumors made up of two different mesenchymal elements, excluding fibrous tissue which is found in all, and counting cartilage and bone as one since they are ordinarily found closely associated. They are thought to arise from primitive mesenchyme as a dysontogenetic growth.<sup>1</sup> They are not always confined to regions where congenital malformations occur but may be found in any organ or soft part.<sup>2</sup> The mediastinum has rarely been a site for either benign or malignant mesenchymomas.<sup>3-11</sup> Only four (2 percent) of the 202 malignant mesenchymomas reported from Columbia University in 1959, occurred in the mediastinum.<sup>11</sup> The purpose of this paper is to present an additional case of malignant mesenchymoma of the mediastinum composed of multiple mesenchymal elements with cytologically malignant characteristics.

### Case Report

A 43-year-old, white woman was admitted to Riverside Methodist Hospital in March 1967 with a four-month history of nonproductive cough without fever, associated with 8-pound weight loss, anorexia, weakness, and intermittent vomiting for two weeks. She had received penicillin and tetracycline for eight days.

Physical examination revealed absence of breath sounds over the right chest with dullness to percussion. The liver edge was two finger-breadths below the right costal margin. The heart had a regular rhythm of 104 beats per minute without murmurs. The lower extremities had a trace of edema bilaterally.

A chest roentgenogram showed mediastinal shift to the left with complete opacification of the right thorax (Fig. 1). Thoracentesis yielded only 10 cc of straw-colored fluid, which contained abnormal cells highly suggestive of malignant neoplasm (Papanicolaou's class IV). Bacterial culture was negative. Complete blood cell count (CBC), urinalysis, fasting blood glucose, blood urea nitrogen (BUN), and serum bilirubin values were within normal limits.

A needle biopsy of the pleura showed neoplastic infiltration consistent with liposarcoma (myxoid variety). Bronchography revealed marked displacement of the lower trachea and both main-stem bronchi to the left

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(Fig. 2), but because of the patient's severe dyspnea and an asthmatic reaction, the examination was not completed. Aminophyllin and Solu-Cortef were given and the patient was sustained with positive pressure breathing. However, she continued to exhibit increased dyspnea, tachycardia, and expiratory wheezing. On the morning of the fifth hospital day, her vital signs were unobtainable and she failed to respond to resuscitative measures.

### Postmortem Findings

On opening the chest, a large encapsulated neoplastic mass, measuring 26 X 20 X 12 cm, was found (Fig. 3). The mass filled the right pleural cavity, producing a cast of the pleural space. It extended across the midline to the left, compressing the left lung and depressing the heart down and to the left. Further dissection revealed no involvement of the thymus gland, which was separate from the tumor. Both lungs were atelectatic, especially the right, which was compressed toward the right apex. No connection between the visceral pleura of the right lung and the mass occupying the right pleural cavity was found. Sections of the neoplasm revealed large areas of yellow fat, bands of fibrous tissue, loculated areas of myxoid tissue, and firm, gristly areas of cartilage with areas of calcification which cut with the resistance of bone. Foci of hemorrhage and necrosis were also found irregularly scattered in the neoplastic mass. No metastasis was found in the mediastinal or hilar lymph nodes, or anywhere else in the body.

Microscopic examination of several sections from various parts of this large neoplasm showed predominantly fatty tissue. There were islands of mature fat (Fig. 4) supported by fibrous bands. Areas of myxomatous connective tissue with stellate or spindle-shaped cells were present. These stained strongly with alcian blue. Focally in these areas of myxomatous tissue, there were seen more cellular areas of less differentiated but more diag-

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FIG. 1. Chest roentgenogram showing opacification of right thorax with deviation of trachea and bronchi to left.



FIG. 2. Bronchogram showing deviation of trachea and bronchi to left.

nostic areas of lipoblasts of spindle shape as well as polygonal shape. Scattered among these were some bizarre, multinucleated giant cells, some with vacuolated cytoplasm, thus providing the clue to their lipoblastic nature (Fig. 5). Such bizarre tumor giant cells were seen even away from areas of hemorrhage and necrosis within the tumor. Fascicles of moderately pleomorphic spindle-shaped tumor cells were seen with plump, elongated nuclei having tapering ends. In some of these foci, there was no evidence of intracellular fat; instead, there was collagen in between these cells, which was therefore indicative of fibrosarcomatous differentiation (Fig. 6). Scattered within the more cellular areas of the neoplasm were seen large strap cells, some of which were multinucleate, and extended across a high power field from one end to the other (Fig. 7). The cytoplasm of these large cells showed a longitudinal fibrillation and a suggestion of transverse fibrillation, which, however, could not be confirmed in the phosphotungstic acid and hemo-

toxylin stains. Such cells probably represent a rhabdomyosarcomatous differentiation. Scattered areas of cartilage with calcification were noted (Fig. 8). In these areas, the chondrocytes were large and varied in size and slightly in shape but these variations were not of sufficient magnitude to be regarded malignant. Irregular calcification of the chondroid matrix was noted. No bone was seen. There were also areas of increased vascularity suggesting angiomatous proliferation (Fig. 9). In some of these blood vessels, extramedullary hemopoietic foci were seen.

#### Comment

It is assumed that this tumor arose from primitive mesenchyme probably on the basis of dysontogenesis and differentiated along different

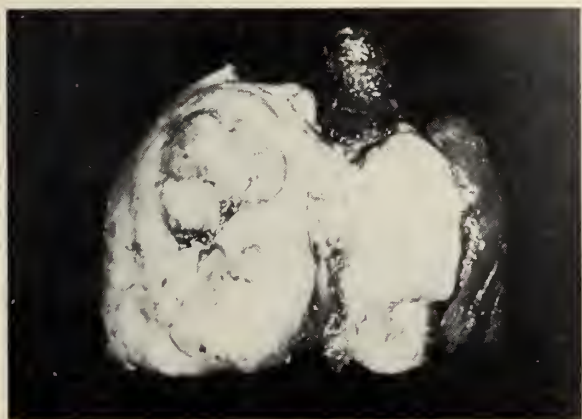


FIG. 3. Anterior view of tumor mass showing larynx, thyroid, left lung, and apex of heart.



FIG. 4. Microscopic section showing lobules of mature fat.



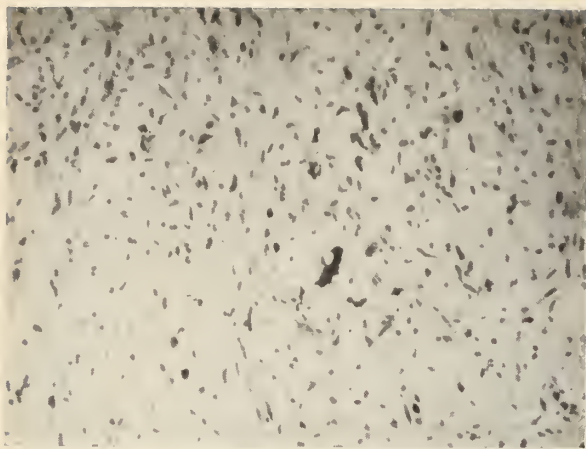


FIG. 5. Area of myxomatous tissue with bizarre tumor giant cell showing vacuolated cytoplasm.

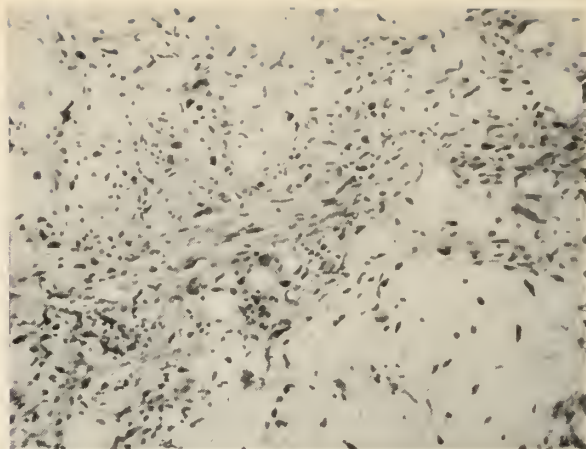


FIG. 6. Area of fibrosarcoma.

cell lines to result in a mixed mesenchymal tumor. However, there are two problems in our case that need elaboration and discussion. First is the possibility of origin of the liposarcoma from a benign lipoma. Although the clinical history of signs and symptoms referable to the mediastinal mass was only of four months duration, the existence of a lipoma for a long period of time cannot be excluded, as it is well known that tumors in the mediastinum may reach very large size before they produce signs and symptoms. Large areas of mature fat within the neoplasm are consistent with lipoma; and foci of well-differentiated myxomatous liposarcoma provide transitions from a benign lipoma to the more pleomorphic, highly cellular liposarcomatous areas, with many bizarre lipoblasts. However, in the absence of a history of a previously recognized mass that grew rapidly in size recently, the possibility of origin of liposarcoma from a pre-existing lipoma cannot be proved.

The second problem of interest is the classification of our tumor as malignant mesenchymoma.

In this connection, Evans<sup>11</sup> is worth quoting: "In some liposarcomas, the plasticity of mesenchyme is expressed to such an extent that the whole range of its reactions is strikingly displayed in various portions of the same growth; thus hemopoietic, angiomatous, cartilaginous, osseous, striated and smooth muscle elements may be differentiated, in addition to adipose tissue in the same mixed tumor. Sarcomatous characters may be exhibited by one or several of these components and for such a growth, perhaps the term 'malignant mixed mesenchymal tumor or malignant mesenchymoma' is more appropriate even if one of the sarcomatous components is liposarcoma." The presence of areas strongly suggestive of rhabdomyosarcoma in our tumor and the extreme diversity of the neoplastic cells in various parts of the tumor, make us classify this neoplasm as a malignant mesenchymoma with predominantly liposarcomatous elements rather than as a pure liposarcoma.

Malignant mesenchymomas can occur in any age group regardless of location.<sup>8</sup> The most com-



FIG. 7. Large multinucleated strap cell with suggestion of transverse fibrillation.

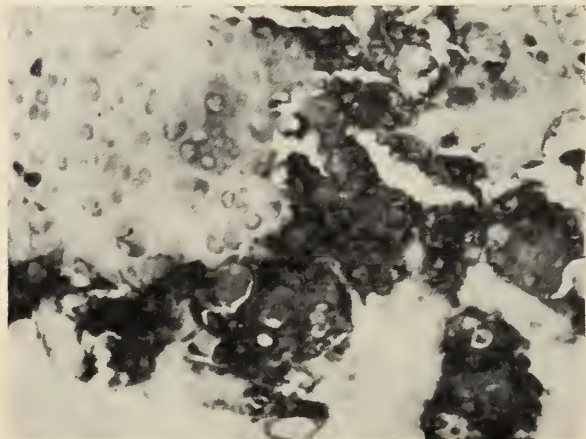


FIG. 8. Focus of cartilage with calcification.

mon symptoms are related to the presence of a tumor mass. In the mediastinum, they seem to reach very large size and are discovered only after extensive mediastinal involvement; complete excision is usually impossible. The prognosis for the patient is dismal but despite this, many patients may survive a number of years after tumor detection. In our case, the tumor had become so large as to compress the respiratory system so that death occurred before definite surgery could be performed.

Increased uses of mass x-ray screening and early investigative surgical procedures of mediastinal masses may help to increase survival rates of some of these patients.<sup>8</sup>

### Summary

Malignant mesenchymoma is a rare neoplasm of the mediastinum. It usually is very large at the time of detection, and resection is usually incomplete. A case in a 43-year-old woman is presented, in which the tumor filled the entire right thorax and anterior left thorax, with compression of the heart and lungs, and caused death in respiratory failure. Although the tumor appeared to be encapsulated, there were histologically liposarcomatous, rhabdomyosarcomatous, and fibrosarcomatous areas, as well as benign angiomatous, hematopoietic, and chondromatous elements. The possibility of a malignant change arising in a preexisting benign lipoma is raised.

### Generic and Trade Name of Drug

Hydrocortisone sodium succinate — Solu-Cortef (Upjohn Company)

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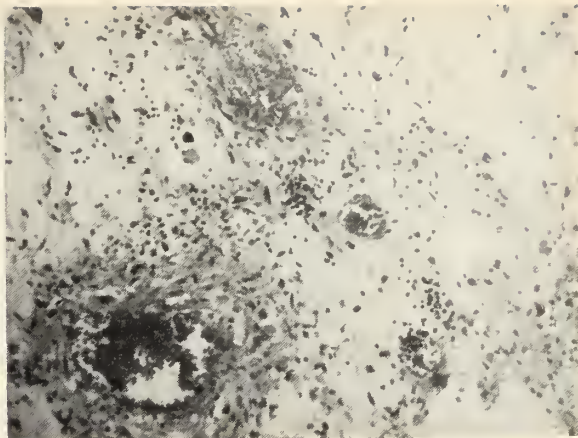


FIG. 9. Angiomatous focus with extramedullary hematopoiesis in a few blood vessels.

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## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

A 50-year-old man enters your office with a one-year history of hoarseness and throat pain. Physical examination revealed a large ulcerated

lesion replacing his left true vocal cord.

Biopsy showed a squamous cell carcinoma. Since the presence of subglottic extension of the tumor would indicate a total laryngectomy as the treatment of choice, how can the inferior extent of this lesion be best evaluated?

(See p. 621 of this issue for further information and discussion.)

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Submitted May 8, 1973.



# Occlusion of Saphenous Vein Aorto-Coronary Grafts

## Case Report of Early Total Occlusion at the Site of Aortic Anastomosis

JOSEF EDELSTEIN, M.D.; JOSEPH KRALL, M.D.; AND ERNESTO LOPEZ, M.D.

SAPHENOUS VEIN BY-PASS GRAFT has been used with very encouraging results<sup>1</sup> in a large number of patients. As with any other form of medical therapy, patients must be properly selected in order to obtain maximum benefits. Improper selection not only can be detrimental to the patient but will also delay the acceptance of this form of therapy as a useful one. We recently had an opportunity to study and follow a patient, preoperatively and during the first few weeks of his postoperative course, who suffered an unusual complication leading to his death. In our opinion, anatomically documented complications following this procedure should be reported in order to gain proper knowledge of all phases of this form of therapy.

### Case Report

This 59-year-old white man was admitted to Mt. Sinai Hospital of Cleveland for the last time on May 3, 1971, and died 13 days later. He had a four-year history of mild-to-moderate exertional angina, which increased in tempo in late 1970. He was treated with standard therapy for angina and had coronary arteriograms performed in December 1970, which showed a normally contracting left ventricle with an end diastolic pressure of 8 mm Hg at rest. The right coronary artery had a complete occlusion one inch from its origin with numerous distal collaterals of small caliber, which also fed the distal portion of the obtuse marginal branch of the left circumflex artery. The main left coronary artery was normal, its anterior descending branch appeared fairly free of disease proximally but had a significant atherosclerotic lesion in its midportion. The left circumflex branch showed multiple areas of moderate-to-severe nar-

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rowing throughout its main course, in addition to the complete occlusion of its obtuse marginal branch. All three main arteries had diffuse "scalloping" along their distal portions.

Because the angina continued despite intensive medical therapy, and because the left ventricle was functioning normally, he was scheduled for coronary artery surgery. While waiting to be operated on, the patient sustained an acute inferolateral, nontransmural myocardial infarction in January 1971, complicated initially by mild congestive heart failure and premature ventricular beats, which were controlled with standard therapy after the first day. His clinical recovery was satisfactory, and cardiac catheterization unfortunately was not repeated preoperatively.

In March of 1971, he underwent a triple saphenous vein by-pass to the distal right coronary artery, to the midportion of the left anterior descending, and to the marginal branch of the circumflex artery. His immediate postoperative course was without complication and the patient was symptom-free for 1½ weeks. However, exertional angina followed by angina at rest returned and the patient was admitted for the last time in congestive heart failure with electrocardiographic changes of subendocardial injury over the inferolateral wall. His hospital course was characterized by intermittent, severe

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Submitted September 21, 1972.



chest pain associated with diaphoresis and worsening congestive heart failure, despite medical treatment with digoxin, diuretics, and antiarrhythmic agents for premature ventricular contractions. His condition slowly deteriorated and the terminal event was characterized by "pump failure" and shock.

Autopsy revealed an enlarged heart (620 gm) with prominent left ventricular hypertrophy. There was an acute and healing myocardial infarction of the lateral and inferior walls. An old infarction was also present in the anterior wall.

Severe atherosclerotic changes were present in the coronary arteries, corresponding to the arteriographic findings. The lumina of two of the vein grafts appeared patent in their entire length. An organizing thrombus occluded the lumen of the vein graft to the anterior descending. The walls of all the grafted veins were thickened. The ostia of all three vein grafts were found to be covered by a thick fibrotic plaque (Fig. 1). The plaque covering the vein grafts can be seen in a longitudinal section through the aorta in Figure 2. Histologically, the plaques covering the vein graft ostia were made up of young, proliferating fibrous tissue covered by a complete endothelialized lining. Serial sections of the vein grafts revealed intimal hyperplasia and fibrosis. These fibroproliferative changes appeared marked at the site of the anastomosis. There was also slight fibrosis of the vein muscle wall and focal fragmentation of elastica.

## Discussion

In retrospect, our patient probably does not exemplify the optimal candidate for direct coronary revascularization. Such patients should have not only severe coronary insufficiency, but, the atherosclerotic lesion should be proximally located with evidence that distal to such a lesion, the vessel is normal. The cardiac muscle should be preserved and be properly functioning. In this type of patient, if the anastomotic site remains free of obstruction, blood flow is guaranteed, and local vein-graft thrombosis will be most unusual, although possible.<sup>1,2</sup> Any degree of disease involving the coronary arteries distal to the anastomotic site will directly influence the blood flow through the graft.

Many factors play a role when clinical symptoms and objective information are analyzed in order to arrive at a decision involving surgery. It was felt in our case that it would be beneficial. The aorto-vein anastomoses were done with interrupted sutures after resecting a small area in the aortic wall. In spite of this, when the aorta was opened during the postmortem examination, it appeared as a continuous endothelial surface with the same glistening appearance covering the anastomotic area as the remainder of the vessel. The interrupted black sutures were underneath this intima. Surprisingly enough, two of the veins were not thrombosed and so this growth of intima over the resected area was not covering a thrombus that initially occluded the vein, but on the contrary, and without an obvious explanation, it filled the gap from one edge to the other in spite of blood supposedly flowing through that area in the presence of a patent vein. When the patient's coronary arteries were studied distal to the veno-arterial anastomotic site, it was found that severe stenotic

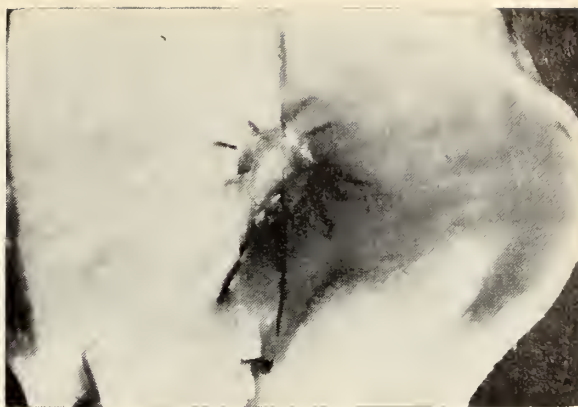


FIG. 1. Figure of one occluded aorto-vein graft site. (Note sutures indicating circumference of grafted vein with former opening completely covered by intimal proliferation.)

areas were present all along the course of all three main vessels precluding free-flow through the graft, and even though two of the veins were not thrombosed, chances are that flow was practically nonexistent, giving an opportunity for this fibrous tissue to grow over the anastomotic site. This presumably caused the failure of the coronary by-pass grafts as well as the resulting clinical symptoms and complications leading to this patient's death. The fresh thrombus found in one of the vein grafts appeared to be superimposed on an already stenosed lumen.

An alternative explanation for the patient's course would be to postulate a post-cardiotomy syndrome, although this seems unlikely in the absence of fever, leukocytosis, or pleural-pericardial involvements. The histology at the aortic anastomotic site also did not suggest this syndrome.

Intimal fibrosis and hyperplasia have been known to occur following arterialization of venous grafts and have been suggested to occur as early



FIG. 2. Longitudinal section of aorta with proximal anastomosis containing thick, fibrotic plaque occluding ostia of vein graft.

as nine weeks.<sup>3</sup> In our patient, this complication occurred less than six weeks postoperatively.

Lesions involving the wall of the grafted veins and thrombosis of the vein itself have been observed in the past.<sup>2</sup> A number of other mechanical complications such as kinking or extrinsic compression of the vein graft are also possible, but to our knowledge, in the absence of a thrombosed vein graft, the complication suffered by our patient strongly suggests that proper consideration of the distal segment of the coronary arteries should be listed as a prime factor in the selection of candidates for direct coronary-artery revascularization if optimal results are to be obtained as previously stated by Dr. Favalaro.<sup>4</sup>

### Summary

A case has been reported of a 59-year-old man with severe, triple-vessel, coronary-artery disease subjected to direct coronary-artery surgery (saphenous vein aorto-coronary grafts). The unusual complication of complete occlusion of all

three aorto-vein anastomotic sites by fibrous tissue and its occurrence within the initial six weeks of the postoperative course are discussed. Possible explanations for these findings are suggested. Proper patient selection by angiography, including the presence of significant proximal obstructive coronary-artery lesions with good distal run-off arterial segments and a preserved myocardium, is of inordinate importance if optimal results are to be expected.

**Acknowledgment:** The authors are very grateful to Norman Pearl, M.D., for referring this patient.

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**MALIGNANT TUMORS OF THE HEART.** —Because of their rarity, primary malignant tumors of the heart continue to evade clinical pre-operative diagnosis. In five cases of malignant heart tumor that were reviewed from the diagnostic point of view, the clinical symptoms and radiographic abnormalities were found to be similar to those produced by more common heart diseases. The diagnosis of malignant cardiac tumor should be considered in a patient with heart disease who has (1) an unusual cardiomedial silhouette, (2) an atypical cardiac calcification, and (3) clinical or radiographic cardiopulmonary findings which do not conform to the expected behavior of the common forms of heart disease. —James W. Laws, M.D.; George P. Annes, M.D., San Francisco; and Hugo G. Bogren, M.D., Davis: *California Medicine*, 118:11-17, April 1973.



# Discussion of E.N.T. Case of the Month

(continued from p. 617)

When evaluating laryngeal lesions, it is often difficult to determine the degree of supraglottic or subglottic extension by direct or indirect laryngoscopy. A useful adjunct in evaluating patients with problem lesions is the laryngogram, a study in which the larynx is coated with radiopaque material and radiographic views are taken.

This patient's laryngogram is seen in Figure 1. Note the narrowing of the subglottic air space on the side of the lesion (left). This indicated a sub-

mucosal spread of the tumor necessitating a total laryngectomy. Note the close correlation between the gross specimen (Fig. 2) and the radiographic findings.

Although laryngograms are valuable adjuncts in the evaluation of patients with laryngeal lesions, a word of caution is in order. They have definite limitations and should never be substituted for direct visualization of the larynx in patients with laryngeal symptoms.

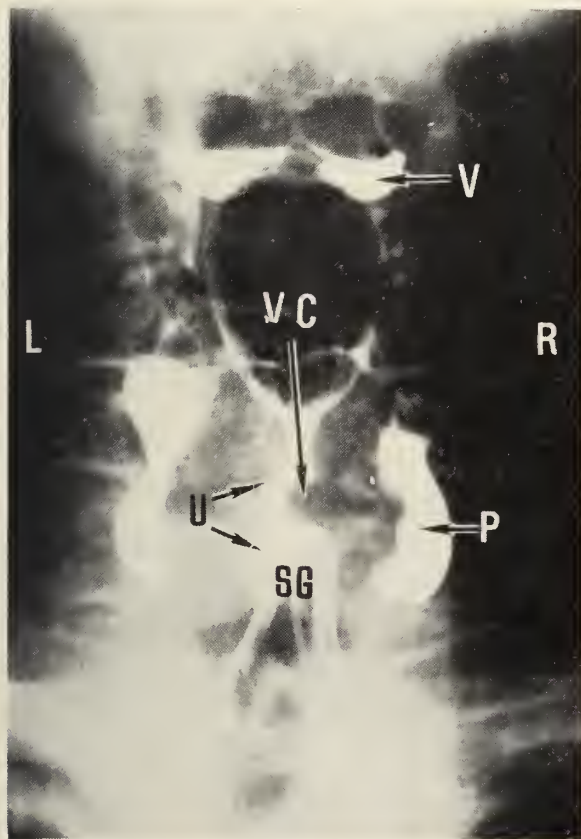


FIG. 1. Laryngogram revealed narrowing of subglottic space (SG) on side of ulcerated lesion (U) indicating submucosal spread of tumor. Also well seen are pyriform sinuses (P), vallecule (V), and vocal cords (VC) on uninvolved right side.



FIG. 2. Extent of tumor invasion on gross specimen correlates well with radiographic findings. Note ulcerative lesion (U) extending well below opposite normal vocal cords (VC).



# Community Health News

## Ohio Department of Health

JOHN H. ACKERMAN, M.D., Deputy Director

### Plasmapheresis-Associated Hepatitis

Plasmapheresis is the procedure by which blood is removed from a donor, the plasma separated from the formed elements, and the formed elements returned to the donor during a single visit to a blood bank. This procedure has enabled donors to give plasma twice a week for long periods of time. The plasma is used for production of hyperimmune sera and coagulation factors. Medical demand for these products has been very great. As a result plasmapheresis centers have opened for profit in many inner cities. These centers generally pay donors a small fee (around \$5.00) for each plasma donation. The centers usually have a bonus program to encourage repeated donations and recruitment of new donors. Although plasma by-products are a valuable part of medical therapy, the growth of plasmapheresis businesses has had some effects which are detrimental to public health.

A serum hepatitis outbreak recently occurred in donors to a commercial plasmapheresis center in Akron. Fifteen cases of hepatitis occurred in plasma donors who denied drug abuse or contact with known hepatitis cases. In addition the center recorded a marked increase in hepatitis-associated antigen (HAA) positive plasma donations during the first six months of 1973. A control blood bank in Akron that collected only whole blood from paid donors had only two hepatitis cases in 1973 donors.

The Akron plasmapheresis center was using a plasmapheresis system that contained many opportunities for blood contamination. The system consisted of seven separate components with risk of contamination each time components were connected or disconnected. In addition wet bloody rags were used over and over again to balance the centrifuge. Most of the personnel had had no formal nursing or medical technological training and used less than sterile technique. Handwashing of personnel was very inadequate.

Commercial plasma donors are mostly poor unemployed men, a population which already has a high prevalence of HAA positivity. A combination of HAA positive blood contamination and unsterile techniques was responsible for spread of serum hepatitis to Akron plasma donors. Regulation of equipment and personnel at plasmapheresis centers will soon be in effect.

### Rocky Mountain Spotted Fever

Recently, the Ohio Department of Health has investigated ten cases of Rocky Mountain Spotted Fever in residents of Clermont, Highland, Lucas, and Franklin Counties. The disease is an acute febrile illness spread by attachment of infected ticks. RMSF has symptoms of fever, headache, and a macular or purpuric rash which characteristically appears first on wrists and ankles. RMSF should be considered in diagnosis of illness associated with fever and rash in areas of tick prevalence during the spring and early summer. Fatal central nervous system and hemorrhagic complications may result if treatment is delayed. Specific therapy for RMSF is tetracycline or chloramphenicol. A rising serum complement fixation titer to *R. rickettsii* distinguishes RMSF from non-rickettsial infections. This test can be obtained from the Ohio Department of Health Laboratories.

Prevention of tick exposure by clothing, repellents, and careful removal of ticks from the body is the best preventive measure. In addition, dogs can be treated to suppress tick infestation. There is no indication for use of RMSF vaccine in the general population.

### Venereal Diseases

The battle to control gonorrhea has gained momentum as public and private medicine join in the all out attack on Ohio's most frequently reported communicable disease. During the first six months of 1973, 165,000 females were cultured. Of these, 6,500 or 4 percent were positive and treated for their infection. These are significant increases when compared with the 115,000 cultured and the 5,864 positives identified during the previous six months. The ratio of male to female cases has been reduced from 1.7:1 to 1.36:1. Total cases reported during this period reflect a slight increase (14,353 vs 14,102). Routine culturing of females during pelvic examinations will enable detection of additional infections and treatment of those identified, thus further reducing the reservoir of females with asymptomatic gonorrhea.

Reported infectious syphilis continues to decrease. The 140 infections reported during the first six months of 1973 represent a decrease of 15.7 percent when compared with the 166 reported during the previous six month period.

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# He has Trichomonas vaginalis?

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Men with trichomonal infection are virtually always asymptomatic, which is why they seldom know they have the disease. But many do have it, nevertheless.

Trichomonal infection is so common that estimates<sup>1</sup> indicate one out of every four women of reproductive age has the disease. *Almost half of the husbands of women infected with Trichomonas vaginalis have it, too.*<sup>2-9</sup>

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- In women, it eliminates trichomonal infection from the vagina, the paravaginal crypts, cavities, and glands.
- Consistent cure rates above 90 percent are to be expected. The rate often approaches 100 percent.
- Simple, sure treatment for women: One 250-mg. tablet three times daily for ten days.
- Simple, sure treatment for men: One 250-mg. tablet twice daily for ten days concurrent with treatment of the female partner.
- Side effects are generally mild and infrequent.
- Flagyl is economical because it is so effective.

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**Indications:** For the treatment of trichomoniasis in both male and female patients and in the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture. The oral tablets are indicated also for acute intestinal amebiasis (amebic dysentery) and amebic liver abscess.

**Contraindications:** Evidence or history of blood dyscrasia, active organic disease of the CNS, the first trimester of pregnancy and a history of hypersensitivity to metronidazole.

**Warnings:** Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

**Precautions:** Mild leukopenia has been reported during Flagyl use; total and differen-

tial leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

**Adverse Reactions:** Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the

mouth, vagina or vulva, pruritus, dyspareunia, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease in libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. Flattening of the T wave may be seen in ECG tracings.

**Dosage and Administration:** For Trichomoniasis. *In the female:* One 250-mg. tablet orally three times daily for ten days. Course may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during, and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high





the vaginal vault each day for ten days and oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole of therapy. *In the male:* Prescribe Flagyl when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period if it is prescribed for the male in conjunction with the treatment of his female partner.

**Amebiasis.** *Adults:* For acute intestinal amebiasis, 750 mg. orally three times daily for 10 days. For amebic liver abscess, 500 mg. orally three times daily for 5 to 10 days. *Children:* 35 to 50 mg./kg. of body weight/24 hours, divided into three doses, for ten days.

**Dosage forms:** Oral tablets 250 mg.  
Vaginal inserts 500 mg.

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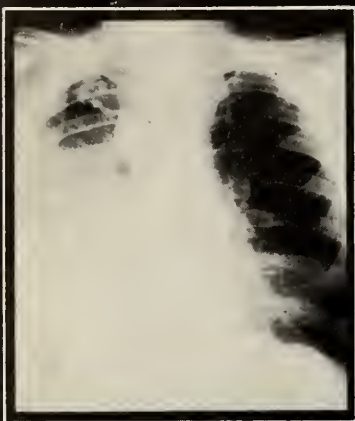
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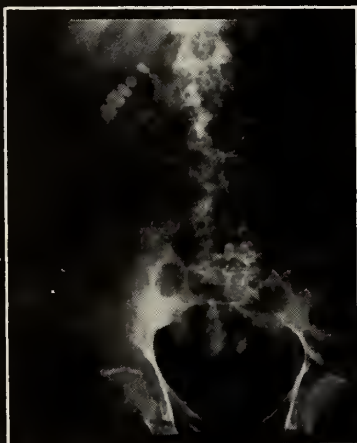
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# Professional Activities



## AMA House of Delegates Actions at the New York Convention

THE AMA HOUSE OF DELEGATES at the 122nd Annual Convention was confronted with the largest business agenda in the Association's history. The House acted on 84 reports and 179 resolutions dealing with issues ranging from PSRO's and wage-price controls to institutional licensure and the need for more primary care physicians.

The Ohio Delegation was quite active at the Convention.

John H. Budd, M.D., Cleveland, was a successful candidate for reelection for a three year term on the Board of Trustees.

Richard L. Meiling, M.D., chairman of the Ohio Delegation, was an unsuccessful candidate for the office of vice-speaker of the House.

### Ohio Resolutions

The Ohio Delegation introduced five resolutions. One of these resolutions calling for a cost breakdown of the cost and expenses of conducting meetings of the House of Delegates and the Scientific Meetings was defeated.

An Ohio resolution recommending that the Board of Trustees discontinue payment of expenses of Specialty Section Council members and Specialty Section Council delegates to attend meetings of the House of Delegates was not adopted.

Several resolutions on the subject of Phase III Controls were considered by the House. One of these resolutions was from Ohio and was introduced at the direction of the OSMA House of Delegates. Action taken by the House on Phase III Controls directed the AMA to continue to work by all lawful and practicable means to assure

nondiscriminatory treatment for physicians under present and future Economic Stabilization Programs.

The "Provider Agreement" under the Medicaid program was the subject of another Ohio resolution introduced at the direction of the OSMA House of Delegates. The House recommended that the Board of Trustees study the legal implications of audits in Ohio of private, non-Medicaid patient records in order to compare private and Medicaid care.

The Ohio Delegation also introduced a resolution calling on the AMA to request the National Intern and Residency Matching Program to abandon its "all or none" policy towards hospitals participating in matching programs. The House was informed that the matter is presently under active consideration by the NIRMP and the Board of Directors. The resolution was referred to the Board of Trustees.

### PSROs

PSROs generated the most discussion at the meeting. Final action by the House on this subject included that the Secretary of HEW be informed that the only organization which can give qualified peer review for physicians' services to the patient, physician, government and taxpayer, are those composed of practicing physicians, whether these are state or local groups; and that there are presently such groups functioning successfully and that regulations to be written should authorize existing peer groups to continue their review as PSROs or as functioning units of PSROs.

The House further resolved that, although it is recognized that repeal or modification of PSRO



legislation ultimately may be required to preserve high quality of patient care, the AMA should oppose any facets of this current legislation, which act to the deterioration of quality care, publicize such deleterious facets, and place highest priority on developing and pursuing appropriate amendments to preserve high quality of patient care.

There were several resolutions pertaining to FDA policies and regulations affecting the practice of medicine. The House adopted a substitute resolution which directs the AMA to, (1) Continue to protest proposed and current regulatory activities of the FDA which have the effect of restricting use of prescription drug to "official labelling"; (2) Study the possibility of proposing modifications to the Food, Drug and Cosmetic Act to correct current problems; (3) Continue to work closely with the FDA in the development of effective methods for evaluating drugs used primarily to alleviate subjective symptoms, or drugs for which controlled clinical studies seem inappropriate; and, (4) In continuing to work closely with the FDA, make efforts to develop an effective system of communicating the views of practicing physicians and medical specialty societies when action is proposed that may result in removal of frequently prescribed drugs from the market.

### Other Third-Party Actions

In other actions affecting the relationship of physicians with government (and third parties), the House:

- Encouraged continued efforts to develop a uniform claim form for insurance claims.
- Supported the on-going efforts to educate physicians, private insurance plans and government agencies as to the advantages of adopting the 3rd edition of Current Procedural Terminology to identify and report services provided by physicians.
- And directed the Council on Medical Service to study the problems presented by "prospective admission" of hospital patients under Medicare and Medicaid, "retrospective denial" of benefits and report its findings and recommendations at the 1973 Clinical Meeting at Anaheim, California.

**Institutional Licensure:** The House adopted a report which calls for the AMA to oppose the extension of institutional licensure in lieu of individual professional licensure to physicians and nurses. Testimony before the Reference Committee was unanimously in support of opposition to institutional licensure.

The Quality Assurance Program (peer review of hospital care and utilization) of the American Hospital Association engendered considerable discussion. The House adopted a report of the Board of Trustees which recommends that AMA repre-

sentatives meet with the AHA to offer its suggestions on the program, and recommends preliminary testing of QAP in a limited number of hospitals. It is emphasized that, "This report is informational and does not imply endorsement of the Quality Assurance Program by the AMA."

### Substitute Resolution Passed

Lengthy debate centered on a resolution from Illinois which protests unilateral changes in medical staff bylaws by hospital boards of trustees that usurp the prerogatives of hospital medical staffs. Similar situations were reported in Arizona and South Dakota.

After considerable discussion, delegates approved the following substitute resolution:

RESOLVED, That the American Medical Association declares that any proposal or arrangement between a hospital board of trustees and its medical staff that conflicts with the AMA principles of medical ethics is improper; and be it further

RESOLVED, That unilateral changes in medical staff bylaws by hospital boards of trustees is also improper; and be it further

RESOLVED, That the AMA suggest that the following preamble be included in all medical staff bylaws:

The hospital and the medical staff have a duty to cooperate in their mutual responsibility of assuring the high quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas in which medical judgment and the evaluation of professional competence are involved, the hospital has a duty to rely upon the judgments and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff.

The House also approved a substitute resolution calling for (1) increased medical staff representation on hospital boards; (2) state and local medical society efforts to remove barriers to such representation; and (3) that the Joint Commission on Accreditation of Hospitals ascertain from its inspectors the effectiveness of communications between hospital governing boards and medical staffs.

The House adopted a substitute resolution which calls for, (1) Continued AMA support for voluntary planning that preserves decision-making at the local level; (2) That state certificate of need laws, if enacted, rest final authority within a

board which includes representation by physicians in the active practice of medicine; and (3) That these recommendations be forwarded to the Secretary of Health, Education and Welfare with the request that they be included in regulations for implementation of the Comprehensive Health Planning Act.

### Education Matters

Another resolution which emphasized the need to increase the opportunities for medical students to obtain exposure to family medicine, was approved and referred to the Council on Medical Education.

The House approved a Board of Trustees report which has important implications for the medical profession and for the public. The report outlines the increase in number of medical schools, the increase in approved residencies and internships, and the increased number of allied health and continuing medical education programs. The report, as amended by the House, also contains two important recommendations. They are:

AMA should adopt immediately, publicize widely and promote vigorously a goal to have at least 50% of all medical graduates enter residency training in the primary care specialties in the coming years.

The need for numbers and type of physicians should be monitored continuously and reassessed periodically in regular reports to the House of Delegates.

**Temporary Licensure for Physicians in Medically-Deprived Areas:** The House adopted a report which encourages state medical societies to support amendments to the medical licensure laws to permit out-of-state physicians to practice temporarily in areas of medical need.

Reaffirmation was given to the tradition of the medical profession of not withholding medical

services (withholding services is a practice of most unions), or performing any act interfering with public welfare. The House also expressed opposition to unionism among self-employed physicians. The policy recognizes that physicians in employment situations need assistance and support, and encourages the Board of Trustees to maintain its interest and concern for these physicians.

The House took several actions in regard to medical malpractice, including approval of a report which outlines the proposed formation of a Medical Liability Commission to represent health care providers in dealing with medical malpractice problems. The proposed commission was outlined on June 20 by a planning committee consisting of representatives of the AMA, AHA, American College of Surgeons, American College of Physicians and four specialty societies. An organizing meeting for the proposed commission will be held in Chicago in September.

### Membership Matters

Recommendations approved in regard to membership certification and dues included the following:

Physicians shall become members of the AMA upon certification by state medical societies rather than by AMA receipt of dues.

The delinquency date for remittance of AMA dues is changed from June 1 to April 30 of each year, and the requirement that members who have been dropped for non-payment of dues must pay one year's past dues is eliminated.

The criteria for exemption from AMA dues shall be consistent with exemption from state medical society dues, except that members reaching their 70th birthday may apply

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directly to the AMA for Active Dues Exempt Membership status.

Elimination of the requirement that AMA membership be limited to those physicians in military service whose tour of duty is two years or more. Younger physicians serving two years or less in the military or the U.S. Public Health Service will be eligible for AMA membership, and county and state medical societies are encouraged to adopt this procedure.

**Formal Planning System for the AMA:** Delegates approved Report D of the Board of Trustees which details a comprehensive, formal, long-range planning system for the AMA designed by Battelle Laboratories, Columbus, Ohio. The plan will improve the AMA's ability to sense change, sharpen objectives, allocate resources, measure progress and improve communications between the AMA and constituent societies and membership.

Dr. Lawrence L. Weed, professor of medicine and community medicine at the University of Vermont, received the \$5,000 Brookdale Award in Medicine. Dr. Weed was honored for development and implementation of the problem-oriented patient record system.

Dr. William B. Castle, internationally known hematologist from Boston, received the sixth annual Dr. Rodman E. Sheen and Thomas G. Sheen Award. He received a plaque and a \$10,000 cash prize.

### Other Actions

In other actions, the House:

- Adopted a substitute resolution recommending that the AMA urge the enforcement of strict penalties for the use of firearms in the commission of a crime.

- Tabled a resolution urging AMA support for the open sale of condoms to minors.

- Referred to the Council on Mental Health a resolution urging AMA support of a model penal code decriminalizing sexual behavior between consenting adults, and AMA support to end legal and employment discrimination against homosexuals. The Council was instructed to report back at the 1973 Clinical Meeting.

- Affirmed the traditional favorable attitude of the medical profession toward pregnancy and motherhood, and encouraged the development of counselling programs that will offer constructive help to prospective mothers in coping with the stresses of pregnancy.

Reaffirmation was given to the AMA abortion policy which states, "Abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in accredited hospitals acting only after consultation with two other physicians, and in conformance with standards of good medical practice and the Medical Practice Act of his state. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of good medical judgment or personally held moral principles."



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# Athens, Reynoldsburg Residents

## Receive OSMA Family Practice Scholarships

THE AWARDING of medical scholarships of \$2,000 each to Christopher L. Demas, of Reynoldsburg, and Donald J. Kennedy, of Athens, was announced in mid-June by the Ohio State Medical Association. They were selected from among 16 candidates who will enter medical school during this summer and fall.

Dr. Oscar W. Clarke, Gallipolis, the Association's President, said this year marked the 25th annual awarding of the scholarships which are a part of OSMA's continuous activities to stimulate



Christopher L. Demas

young men and women of Ohio in becoming Doctors of Medicine, with emphasis on their becoming family physicians serving Ohio residents.

The two winning candidates were selected in competition judged on the basis of character, integrity, intelligence, mature personality, need, interest in community life, leadership and scholastic ability.

Demas, 20, was graduated from Maple Heights High School, Maple Heights, Ohio, in 1969. He recently completed his premedical education at Ohio University, Athens. He received the DeMolay of the Year Distinguished Service Award in Ohio for scholarship in 1970 and was on the Ohio University Dean's List for outstanding scholarship. Prior to beginning his medical studies at The Ohio State University College of Medicine in July, Demas worked as a laboratory and field service technician for Pro-Chem, Inc. of Cleveland.

In his letter of application, Mr. Demas explained that "if the medical profession is willing to accept people doctors back into its ranks of scientist doctors, then this new specialty (family



Donald J. Kennedy

practice) has the potential of blossoming into a discipline which would dictate that its members could be of no greater service to their community and thus, to their society than to be a Family Physician. I choose to take up the gauntlet."

Kennedy was graduated from St. Ignatius High School, Cleveland, in 1964. He attended Stevens Institute of Technology, Hoboken, New Jersey, and received a Bachelor of Engineering degree prior to transferring to Ohio University for the completion of his premedical requirements. Kennedy will enter the University of Cincinnati College of Medicine this fall.

While attending Ohio University, Kennedy worked as an orderly and laboratory assistant at Mt. St. Mary's Hospital, Nelsonville. His wife is a receptionist for the Ohio University Botany Department.

Mr. Kennedy explained in his letter of application that he wishes to become a family physician "because I feel it will best combine my scientific interests with my desire to deal with many different people, of different ages and with a variety of problems. The primary role of a family physician is to practice good medicine, but he must also be able to teach and explain the reasoning and nature of his profession. I would like to accept that role."

Dr. Clarke, in his announcement, said that as

of this fall there will be eight students in medical colleges receiving Family Practice Scholarship funds.

In addition to Messrs. Demas and Kennedy, the others are: Mrs. Phyllis Ann Hutson, Maple Heights (Case Western Reserve University School of Medicine); Carl S. Wehri, Cloverdale (Ohio State University College of Medicine); Donald M. Miller, Upper Sandusky (Medical College of Ohio at Toledo); Albert J. Weisbrot, Cincinnati (University of Cincinnati College of Medicine); John E. Pappas, Cuyahoga Falls (Temple University School of Medicine), and John H. Surry, Youngstown (St. Louis University School of Medicine).

## Continuing Medical Education Courses for Physicians

### August

**Fifth Semiannual Short Course on Laser Safety**—Sponsored by the Medical Laser Laboratory and the office of Continuing Medical Education (CONMED) of the University of Cincinnati; August 6-10; at the University; tuition \$325; course director, R. James Rockwell, Jr., for details contact CONMED, 114 Medical College, Cincinnati 45219; phone 513/861-8000, Ext. 405.

### September

**Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Symposium on Implementation of the Recommendations of the Secretary's Commission on Malpractice, Sept. 6.**

**Infertility**—Educational Forum cosponsored by the Cleveland Society of Obstetricians and Gynecologists, at the Cleveland Clinic, September 12, beginning at 3:00 p.m.; Nicholas Vorys, M.D., Dept. of OB-Gyn at Ohio State University, guest speaker; dinner and evening meeting, 7:00 p.m., Dr. Vorys to speak on **Hirsutism**. Contact Lester A. Ballard, Jr., M.D., at the Cleveland Clinic, 9500 Euclid Ave., Cleveland 44106.

**Tri-State Regional Meeting, American College of Physicians, September 28-29, Salt Fork Lodge, Cambridge.** For information, write William H. Bunn, Jr., M.D., 4025 Whippoorwill Way, Youngstown 44505. The Tri-State Region includes Ohio, Western Pennsylvania, and West Virginia.

### October

**Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; Dermatology for the Non-Dermatologist, Oct. 10-11; Current**

**Status in Artificial Organs, Oct. 19-20; Pediatric Endocrinology, Oct. 24-25.**

**Northwestern Ohio Medical Association, annual meeting and scientific session, Holiday Inn, Bowling Green, Oct. 31; 10:00 a.m. to 4:00 p.m.; contact Marjorie E. Conrad, M.D., president and chairman, 15819 Bowling Green Road West, Bowling Green 43402.**

### November

**Occupational Medicine and Environmental Health**—2-week full-time course with emphasis on clinical and environmental hygiene problems, coverage of OSHA; November 5 to November 16; tuition \$600; for details contact Sidney Lerner, M.D., Kettering Laboratory, Department of Environmental Health, College of Medicine, University of Cincinnati, Cincinnati, Ohio 45219.

**Toxemia of Pregnancy**—Educational Forum sponsored by the Cleveland Society of Obstetricians and Gynecologists, at the Marriott Inn, 4277 W. 150th Street, Cleveland, November 14, beginning at 3:00 p.m.; guest speaker, Russell DeAlvarez, M.D., Temple University; dinner and evening meeting, 7:00 p.m. with Dr. DeAlvarez continuing the discussion on the same subject. Contact Lester A. Ballard, Jr., M.D., Secretary, Clinic Center, 9500 Euclid Avenue, Cleveland 44106.

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**(See Page 644)**

# State Medical Board Policy on Acupuncture

**F**OLLOWING is a policy statement issued by the State Medical Board, State of Ohio, the text of a news release issued to the public press, and the Food and Drug Administration Guidelines referred to in the statement.

\* \* \*

## STATE MEDICAL BOARD POLICY ON ACUPUNCTURE

On Wednesday, June 13, 1973, the State Medical Board adopted, as a matter of policy, the guidelines contained in the Food and Drug Administration announcement dealing with acupuncture as published in the Federal Register, Volume 38, No. 46, Friday, March 9, 1973. In adopting these guidelines the Medical Board recognizes acupuncture as being an investigational procedure in which case all subjects receiving acupuncture must have given informed consent. Moreover, that such investigational procedure will only be conducted by a Doctor of Medicine or a Doctor of Osteopathic Medicine fully licensed by the Ohio State Medical Board. Lack of conformance with the before-stated guidelines is considered grossly unprofessional conduct within the meaning of Section 4731.22, Ohio Revised Code.

\* \* \*

## NEWS RELEASE

Ohio physicians must now obtain "informed consent" before performing acupuncture on patients, William J. Lee, Administrator of the Ohio State Medical Board said.

Only fully licensed medical doctors and doctors of osteopathy may perform acupuncture and they must first give the patient a fair and full explanation of the treatment and its hazards, Lee said.

It is suggested that physicians also obtain approval and review of acupuncture treatment from their hospitals or county medical societies.

Mr. Lee said that the U. S. Food and Drug Administration states that, "the safety and effectiveness of acupuncture has not been proved or generally accepted."

Only acupuncture devices labeled in accordance with U.S. FDA guidelines may be used by physicians. Labels must include the statement, "Caution: Experimental devices limited to investigational use." Mr. Lee said that lack of in-

formed patient consent or the use of unlabeled or improperly labeled devices shall be considered grossly unprofessional conduct by the Board.

Mr. Lee said that the Ohio Board action was taken in accordance with recent U.S. FDA guidelines relating to acupuncture.

\* \* \*

## FDA ANNOUNCES GUIDELINES FOR PROPER LABELING OF ACUPUNCTURE DEVICES FOR INVESTIGATIONAL USE

The Office of Medical Devices of the Food and Drug Administration called a limited conference in Washington, D.C. in September 1972, inviting representatives from a number of professional organizations concerned with acupuncture. The Federation was represented at that conference, and a preliminary discussion of the conclusions reached during that day-long session was printed in the November 1972 BULLETIN.

Reflecting FDA's official position in regard to the labeling of acupuncture devices, the following statement — printed as a *notice* in the *Federal Register* — clearly indicates the continued classification of those devices as appropriate only for investigational use, under the direct supervision of a licensed physician or dentist.

## ACUPUNCTURE DEVICES LABELING

### Notice to Manufacturers, Packers and Distributors

The Commissioner of Food and Drugs is aware of the current interest in the United States surrounding the use of acupuncture needles, stimulators, and other accessories for medical purposes. Acupuncture paraphernalia are being imported into this country and are also being manufactured domestically for various medical uses, including the treatment and diagnosis of serious diseases, anesthesia, and pain relief. These products are devices and must comply with all applicable provisions of the Federal Food, Drug, and Cosmetic Act.

It is the position of the Food and Drug Administration that the safety and effectiveness of acupuncture devices have not yet been established by adequate scientific studies to support the many and varied uses for which such devices are being promoted, including uses for analgesia and anesthesia. Although various theories have been advanced as to how medical results can be obtained through the use of acupuncture, none has been proved or generally accepted, and there is a body of scientific opinion which questions the safety and



effectiveness of acupuncture in many of the uses for which it is now being applied.

Under the Federal Food, Drug, and Cosmetic Act, all devices must be properly labeled to be in compliance with the law. Devices which are not safe for use by the laity, or for which adequate directions cannot be written for safe use by the laity, must be labeled as prescription devices and must be accompanied by labeling which provides the prescribing practitioner with adequate directions for their safe and effective use. Because the safety and effectiveness of acupuncture devices have not yet been adequately demonstrated, and labeling therefore cannot be devised, which would provide adequate directions for safe and effective use, they may not be labeled in accordance with the requirements for prescription devices as stated in 21 CFR 1.106(d). Until evidence is obtained demonstrating that acupuncture is a safe and effective medical technique, acupuncture devices must be limited to investigational or research use.

Current Food and Drug Administration regulations do not contain specific provisions governing the shipment of investigational devices in interstate commerce for clinical research or experimental use. The Commissioner of Food and Drugs is aware of the need for such regulations to provide adequate guidance as to the labeling for experimental devices to be used on human beings. Therefore, the Commissioner intends to publish at a later date proposed regulations which would govern all investigational devices. In the interim, this notice will apply to all acupuncture devices.

In order to establish guidelines under which manufacturers, packers, and distributors can properly label acupuncture devices for investigational use, the Food and Drug Administration met on

September 22, 1972, with individuals concerned with the use of acupuncture in the United States. These included representatives of the States of California and New York, the city of New York, the American Society of Anesthesiologists, the National Institutes of Health, the Federation of State Medical Boards, the American Medical Association, medical practitioners, and the Food and Drug Administration Medical Device Advisory Committee. It was the consensus of this group that acupuncture devices should be restricted to investigational use by licensed practitioners and that the labeling for these devices should include this restriction in addition to other information.

Accordingly, the Commissioner of Food and Drugs concludes that until substantial scientific evidence is obtained by valid research studies supporting the safety and therapeutic usefulness of acupuncture devices, the Food and Drug Administration will regard as misbranded any acupuncture device shipped in interstate commerce if the following information does not appear in the labeling:

- (a) The name of the device.
- (b) The name and place of business of the manufacturer, packer, or distributor.
- (c) An accurate statement of the quantity of the contents.
- (d) The composition of the device and whether it is sterile, nonsterile, reusable, or disposable.
- (e) The dimension or other pertinent physical characteristics of the device.
- (f) The following statement: "Caution: Experimental device limited to investigational use by

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**Warnings**—Not recommended during the first and third trimester of pregnancy. Caution patients against possible combined exaggerated effects with barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in impairment of vision, paralysis of accommodation and impaired hypnosis. Caution patients concerning operation of a motor vehicle, operating machinery, or hazardous operations requiring alertness after taking the drug. Administer with caution to patients with suicidal tendencies and do not prescribe large quantities of the drug. Adjustment of dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCY. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM, CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 10 MG. PER DAY OVER A PERIOD OF SEVERAL WEEKS WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF PLACIDYL IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosage of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or rebound symptoms. Signs and symptoms associated with withdrawal and abstinence include undue anxiety, tremor, ataxia, slurring of speech, loss of appetite, perceptual distortions, irritability, and delirium. Other less well defined withdrawal symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea, vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuation of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Adverse Reactions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, but amblyopia has improved after discontinuation of the drug. Drug dosage should be limited to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after the patient has been controlled with analgesics. Caution is advised in prescribing the drug for patients who are treated with either MAO inhibitors or anti-anxiety agents. Transient delirium has been reported with combination of Placidyl and amitriptyline. Dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients may respond unpredictably to barbiturates or alcohol who exhibit excitement and release of inhibition in association with such agents, may also respond in this way to Placidyl. Rarely, patients may experience symptoms suggestive of an unusual sensitivity to the drug; such as prolonged hypnosis, muscular weakness, excitement, hysteria, hypotension without marked hypotension. Transient ataxia or ataxia may occur.

**Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, drowsiness, facial numbness, and allergic reaction have been reported. Urticaria have been reported following administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. Cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 302430R



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**INDICATIONS:** *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in:

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- primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia)
- secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis)
- traumatic lesions, inflamed or suppurating as a result of bacterial infection.

*Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

**CONTRAINDICATIONS:** Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

**PRECAUTION:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

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or under the direct supervision of a licensed medical or dental practitioner. This device is to be used only with informed consent under conditions designed to protect the patient as a research subject, where the scientific protocol for investigation has been reviewed and approved by an appropriate institutional review committee, and where conditions for such use are in accordance with State law."

Instructions for the use of the device for the purpose for which it is being investigated and, to the extent such information is known, any human hazards, contraindications, precautions, or side effects associated with its use, should be provided to researchers and investigators. The Food and Drug Administration, however, will regard as misbranded any acupuncture device shipped in interstate commerce if accompanied by claims of diagnostic or therapeutic effectiveness.

Pending promulgation of separate regulations for conducting clinical investigations of investigational devices, researchers and investigators shall assure adequate informed consent and institutional committee review for such investigations, utilizing as a guideline the standards established for investigational drugs in 21 CFR 130.37 and in Division 10, unit C of form FD-1571, in 21 CFR 13.3(a) (2).

Dated: February 21, 1973.

SHERWIN GARDNER

*Deputy Commissioner of Food and Drugs*

In addition, the director of the Office of Medical Devices, Office of the Associate Commissioner for Medical Affairs at FDA, emphasized in a letter accompanying the "notice" in the *Federal Register*:

The following statement must appear in the labeling: "Caution: Experimental device limited to investigational use by or under the direct supervision of a licensed medical or dental practitioner. This device is to be used only with informed consent under conditions designed to protect the patient as a research subject, where the scientific protocol for investigation has been reviewed and approved by an appropriate institutional review committee, and where conditions for such use are in accordance with state law."—Ed.

*Federal Register*, Vol. 38, No. 46—Friday, March 9, 1973.

## New Quarterly for Medical Writers Now Being Published

*Medical Communications*, a new journal for medical writers, editors, and broadcasters, has been introduced by the American Medical Writers Association.

Featuring papers and editorials by both members and nonmembers on subjects dealing with medical communications, the new journal will be published quarterly, according to Dr. M. J. Schifffrin, President of AMWA.

The purpose of the new journal, Dr. Schifffrin stated, is not merely to reflect the point of view of the AMWA membership, which consists of nearly 1,500 medical writers, editors, publishers, pharmaceutical writers, illustrators, audio-visual writers, scientists, and clinicians, but hopefully also serve as the vehicle for introducing new concepts and ideas.

Requests for subscriptions (\$5 per year) should be sent to: American Medical Writers Association, 9650 Rockville Pike, Bethesda, Maryland 20014.

Proposed articles, editorial contributions, and letters for publications should be addressed to: Mr. Byron T. Scott, Editor, 166 East State Street, Athens, Ohio 45701.

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The Central Ohio Chapter, American Association of Critical Care Nurses, in cooperation with the Kidney Foundation of Central Ohio is offering a symposium entitled "The Acutely Ill Patient with Renal Disease" in Columbus, October 3-4. The place is the Imperial House North, on Morse Road at I-71. Registration fee is \$30. For more information, contact Lynn England, President, 6092 Batavia Road, Westerville 43081.

# Woman's Auxiliary Highlights

By MRS. S.L. MELTZER, Publicity Chairman  
2442 Dornan Drive, Portsmouth 45662

I DIDN'T "make" it this year—to New York and the annual convention of the Woman's Auxiliary to the American Medical Association, which, for many reasons, I truly regret. Also, since New York is my home town, I always look forward to my additional role as guide there (although I'm usually accused of wearing out my colleagues in the process).

Fortunately for me and this column, Mrs. Louis Loria, Ohio's immediate past president and presidential delegate to the convention, agreed to be my "stand-in" and send back some of the 1973 highlights, which she has ably done and for which I am most grateful.

AMA-ERF made the big news. Ohio won two awards—the Regional Merit Award for the greatest increase in the North Central Region and a Special Merit Award for the greatest per capita—\$20.70. Ohio's total contribution this year was a whopping \$103,059.00. When I wrote our own state convention story, I said that the total figure then given would undoubtedly be higher by the time of national convention. Was it ever! I also suggested a twenty-gun salute to AMA-ERF chairman, Mrs. Henry Holden, and AMA-ERF treasurer, Mrs. R. A. Wiltsie. Now I recommend a forty-gun salute. . . .

The AMA-ERF awards were presented at the Monday luncheon, but I'm a little bit ahead of myself where the chronological order of the national convention is concerned. (Ohio's Big News should merit first mention. I figure). OK, then—let's backtrack a bit to Sunday, June 24th and the Empire Room of the Waldorf-Astoria, and see things through the eyes of Eileen Loria.

Five p.m. ushered in the gala reception for Mrs. Robert Beckley, WA-AMA president, and Mrs. Willard C. Scrivner, president-elect. It was the usual beautiful, happy, getting-to-know-you festivity that brings together the medical family from all over these United States. There is always something very special about this occasion.

## Monday Doings

Early Monday morning (7:30 a.m.) was Ohio's traditional "moment"—the annual breakfast for delegates, alternates and special guests. This year, 26 were in attendance. The attractively

appointed tables featured, alongside each place card, a lovely red-beaded carnation with green leaves, the exquisite handiwork of the talented Mrs. Henry Crawford of Cuyahoga County. Each delegate and alternate wore this very special corsage throughout convention, the "identifying mark" of Ohio (for those who may not know it, the red carnation is our state's official flower).

Mrs. Karl Ulicny, new state president, presided at the breakfast. A discussion was held about the proposed new Bylaws. It was decided not to nominate anyone from Ohio this year for the national Nominating Committee, but rather to lay the groundwork for such a nomination next year. Mrs. Ulicny introduced each member of the Ohio delegation as well as each guest. She also explained the duties of the delegates.

## Keynote Speaker

The formal opening of the convention and general meeting in the Grand Ballroom got off to a good start at 9:00 a.m. The keynote speaker was Harry Schwartz, author of *The Case for American Medicine* and member of the *New York Times* editorial board. He reiterated basically what is in his book but he noted the difference in being called a good friend of medicine and a friend of good medicine. "I am a friend of good medicine," he said. He referred to the TV specials concerning medicine (such as What Price Health) and he called them very lopsided, biased and hate propaganda.

## "Why" the Criticism

In discussing the "why" of the criticism of medicine, Mr. Schwartz gave six specific reasons: (1) There are defects in medical care delivery, particularly in those sections in the country low on physicians, such as the rural areas and the ghettos. (2) For the seriously ill, medical care does cost a lot of money. "We need a system for catastrophic medical care." (3) People tend to remember unpleasant incidents with regard to doctors. (4) Negative news in any area is always more saleable. (5) The strongest single force underlying criticism of medicine is envy. Doctors make more money than any other profession. (6)

There is an attitude of conviction of socialism across the country—a "Health Is A Right" attitude.

"I think socialized medicine means bureaucratic medicine," Mr. Schwartz said. "And as such we would have utter catastrophe." He commented on the fact that both parties ignored "The Health Care Crisis" in the 1972 election, so it would seem as if the politicians do not really believe there is a crisis. He feels that most of the public really knows that "medicine" in this country is pretty good but he admitted that the relatively fewer critics are very vocal yet.

"Be conscious of the real faults," the newspaper executive urged, "and try to correct them. Look for ways of making medical care more economical, possibly through the channels of preventive medicine. Get to know all the facts and step into the socioeconomic field."

The annual luncheon honoring AMA officers, trustees and their wives was held at the Waldorf's Starlight Roof. Dr. Carl A. Hoffman, 1972-73 president, addressed the delegates and guests.

### Idea Exchange

At 2:30 p.m., delegates gathered for the always interesting and informative "Idea Exchange"—the state presentations on the year's outstanding projects. Mrs. Loria's report featured Ohio's Health Education activity and the formation of the Speakers' Bureau.

"Prior to my taking office as state president," said Mrs. Loria, "I asked the OSMA president-elect if there were areas in which he could use our help in the coming year. One of the things he requested was that we form a Woman's Speakers' Bureau to 'up' the doctors' image and to bring important health information before the public."

Mrs. Loria then went on to describe to the national convention the various important steps that finally led up to the Speakers' Training Session held in September of last year under the auspices of the Ohio State Medical Association. Twenty-five women participated in the day and a half session (which also included evening hours). Subsequently, brochures with speech topics were distributed to the counties to be given to local groups with the name listed of a local member of the Speakers' Bureau, or if there were no such local member, then the name of the chairman of the state Program Development Committee. Material was given to each member of the Speakers' Bureau relative to speech topics to help her in preparing her particular talk.

In addressing the national convention's Idea Exchange, Mrs. Loria made this comment: "Recently we felt the need to revise our brochure with

fewer available topics, more catchy titles and with a sentence or two of explanation as to what they are about . . . they are now being redistributed so that the chairmen of the local community health groups will have a chance to include them in program planning during the summer months . . . we feel that not getting them out until late fall last year was a definite drawback." Ohio's 1972-73 president elaborated on Montgomery County's Speakers' Bureau which was started in response to the Social Health Association's request for more speakers on the subjects of venereal diseases and sex education. The Montgomery County women attended a concentrated course of classes on these two important subjects.

### Dorothy Sarnoff

The luncheon on Tuesday, June 26 honored the National Past Presidents and Honorary Members. Dorothy Sarnoff, director of Speech Dynamics, Inc., New York, was the guest speaker. Her topic was "Speech Can Change Your Life." "What offends the eyes and ears colors the picture the eye beholds," she said. She declared that we speak in five "languages"—first, ideas, images, words; second, tone which can repel or attract; third, eye contact which should be there 90% of the time; fourth, facial expression; and fifth, body posture and movement.

"The effectiveness of a speech depends," said Mrs. Sarnoff, "on how one prepares, organizes and edits . . . a speech should have the quality of a conversation . . . work from cue phrases, do not use word for word text . . . have a positive attitude toward yourself and your audience. . . ."

Her closing remarks dealt with how to listen well: With eyes, ears, heart and mind; do more than listen—**understand**; do more than see—**look**; do more than talk—**say something**.

### Child Abuse

The Wednesday afternoon, June 27, keynote speaker was Vincent J. Fontana, M.D., chairman of Mayor Lindsay's Task Force on Child Abuse and Neglect. He is director of pediatrics at St. Vincent's Hospital and Medical Center of New York and medical director of the New York Foundling Hospital.

"It has been estimated," he said, "that at least 700 children are killed every year in this country by their parents or surrogates. Thousands of other children are permanently injured, both physically and mentally. In New York City in 1971 there was more than a 500 percent increase in reported cases of abuse and neglect within the period 1966-1970."

Dr. Fontana acknowledged that violence is a social disease of epidemic and endemic propor-



tions which is becoming more entrenched in our population. "Child abuse, a symptom of the violence running rampant in our communities," he said, "results in social disorganization and disintegration . . . this generation's battered children, if they survive, will be the next generation's battering parents. Recent published reports suggest that hard-core criminals and murderers in our society were formerly battered and abused as children."

The future of the abused child, the speaker pointed out, is dependent on the education and enlightenment of all people concerned with child care, upholding the laws of the various states and finding means of reporting that will make protection of the child and subsequent investigations of child abuse more realistic and more efficient. One of the National Auxiliary's top priorities this 1973-74 year will focus on the battered child syndrome.

### Inaugural Address

Mrs. Willard C. Scrivner, of Illinois, was installed as president of the Woman's Auxiliary to the American Medical Association Wednesday morning, June 27. In her inaugural address, she challenged the critics of organized medicine. "Somehow, the idea that there is a 'crisis in our present health care system' has been accepted by many people," she said. "Some critics in and out of government falsely maintain that organized medicine has restrained medical school enrollment and physician supply. Yet the facts are physician supply is increasing about three percent a year while the general population increase is less than one percent."

Mrs. Scrivner went on to say that in almost every instance organized medicine directly or indirectly, through various activities including legislative persuasion, has been instrumental in increasing our nation's medical schools from 85 to 110. "Furthermore," she added, "it has been estimated by a reliable source that an adequate number of physicians will be obtained by 1980. It would seem desirable to separate fact from fallacy. For **health care**, including distribution of physicians, is a responsibility of all our citizens while

**medical care** is a major responsibility of the medical profession."

Some other remarks of the new national president included: "As an auxiliary, this is but one example of a part of our obligation to know the facts in order to repute misrepresentation by our critics . . . we must be informed, involved, articulate, 90,000 strong through national, state and county auxiliaries. . . . An official physician survey revealed improved communication and public relations among their top priorities. Just think what a P. R. job we could do if every eligible physician's wife joined our ranks. The two words "Information" and "Communication" are often used interchangeably, but they signify quite different things—information is **giving out**; communication is **getting through**. . . .

"We firmly believe our auxiliary, the public, our communities will benefit most from a skillful orchestration of all our efforts rather than the temporary blinding light of a shortlived super star, for wearing your halo too tightly gives others a headache too . . . our tasks as an auxiliary are many—our goal is clear—to aid the medical profession in its objectives and work for improvement in the quality of life through better health care for every American."

### The Ohio Delegation

Here's our 1973 "Who's Who," Mrs. Louis Loria, Trumbull, Presidential Delegate; Mrs. Karl Ulicny, Columbiana, Chairman of Delegates; Mrs. Emil Barrows, Hamilton; Mrs. Dwight Becker, Allen; Mrs. George Bates, Lucas; Mrs. Joseph Barker, Licking; Mrs. J. A. Budd, Cuyahoga; Mrs. Christopher Colombi, Cuyahoga; Mrs. Henry Crawford, Cuyahoga; Mrs. Carl Frye, Licking; Mrs. Carl F. Goll, Jefferson; Mrs. Reuben Gould, Cuyahoga; Mrs. S. J. Glueck, Clark; Mrs. Jerry Hammon, Miami; Mrs. F. Karaffa, Licking; Mrs. Edward Kieger, Cuyahoga; Mrs. Robert Krone, Hamilton; Mrs. William Mikita, Jefferson; Mrs. J. Paul Sauvageot, Summit; Mrs. Malachi W. Sloan, Montgomery; Mrs. J. H. Thomas, Trumbull; Mrs. Howard Van Ordstrand, Cuyahoga; Mrs. Russell Wiessinger, Allen; Mrs. James N. Wychgel, Cuyahoga. Welcome home!

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17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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OHIO, FAIRFIELD, Space available in modern Medical Building, 15 miles from Cincinnati. General Practitioner and Specialist needed. Reply to Box 616, c/o The Ohio State Medical Journal.

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio, Phone 271-0291.

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DIRECTOR OF FAMILY PRACTICE PROGRAM: The search committee of the Family Practice Residency Committee of the Toledo Hospital, Toledo, Ohio 43606, is prepared to interview interested physicians for a full-time position in a new Family Practice Residency Program to begin about September 1, 1973. For information or an appointment for interview please contact: Henry R. Silverman, M.D. 4352 Sylvania Avenue, Toledo, Ohio 43623. Telephone: 419/882-7165.

WANTED — General Practitioners. Are you tired of the rat race? There is a great need for your skills in the modern day Mental Health field. Please consider working at a swinging Mental Health Center in Southeastern Ohio in an active college town. For a licensed G.P., the minimum starting salary would be \$20,592 plus additional pay for any overtime above the usual 40 hour work week. Fringe benefits include 2 weeks vacation after 1 year duty, accumulation of sick-leave time, a 50-50 pay basis for Comprehensive Medical Insurance coverage and paid Life Insurance on a graduated scale after 1 year service. Many opportunities for continuing education and for advancement. Generous meeting and travel time. NO OVERHEAD. If at this point you need further information, write: Superintendent, Athens Mental Health Center, Athens, Ohio 45701.

FOR SALE: Physicians Examining Table; Burdick EKG Machine, (late model) and a new Sterilizer. Contact W. H. Miller, M.D., 328 E. State St., Columbus 43215. Telephone 614/221-3743.

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**GYNECOLOGICAL CONSULTANT** needed for part time work in the Student Health Service at Miami University, Oxford, Ohio, starting in September 1973. Contact Director of Health Service, MacMillan Hospital, Oxford, Ohio 45056.

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**Reference:** 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1960. 3. Tietz, A. S. Methyltestosterone thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Wetman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid androgen interrelations and the hypochlosteremic effect of androstosterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Cotton, S. W. Effects of Lithroxine and Iothyrone on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensary (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.



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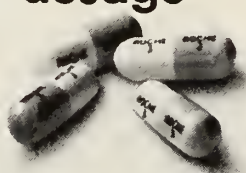
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**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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SEPTEMBER • 1973  
VOL. 69 NO. 9

# *The Ohio State* MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION



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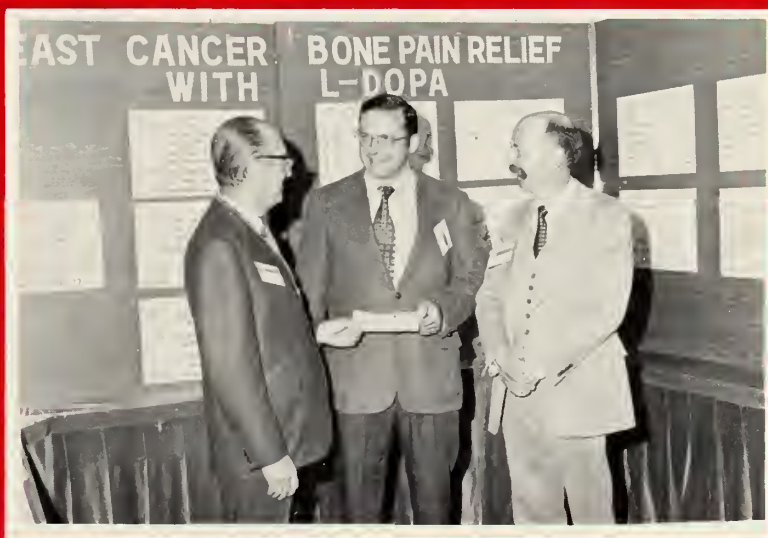
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Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

# Valium® (diazepam)

To help you manage excessive psychic tension



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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during July. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

**ADAMS**  
Bruce M. Ashley  
Blue Creek

**CLARK**  
D. Preston Figge  
Springfield

**CUYAHOGA**  
Khaled Chaouki  
Cleveland

**ERIE**  
Edward C. Meisler  
Sandusky

**LAKE**  
John H. Paul  
Cleveland

**LAWRENCE (Ironton)**  
Portia Vera C. Canos  
Rodolfo J. Canos  
David A. Pack

**LUCAS**  
Thomas G. Kirkhope  
Toledo

George D. Ludwig  
Toledo

**MAHONING**  
(Youngstown)  
Lorenzo M. Farolan  
Reese E. James  
Nora S. M. Natividad  
Gopal J. Nigam  
Josef R. Smith

**MARION (Marion)**  
Edward L. Charnock  
Hanwon Cho  
James S. Hering  
Ernest W. Hetrick  
Geoffrey H. Wilson  
Escarlito U. Sevilla

**MEDINA**  
Lily A. See  
Medina

**MONTGOMERY**  
Ceferino J. Cata-Lage  
Dayton

**TRUMBULL**  
Kmalakama Reddy  
Warren

## Cincinnati Medical College Continues Expansion

September 17 convocation ceremonies for the opening of the 154-year-old College of Medicine of the University of Cincinnati also marks the first day of classes for 120 incoming freshmen. It is the last year for that number, since in September, 1974, the first-year class is scheduled for an increase of 192 men and women.

The increase will be made possible by greatly expanded facilities designed into a new college headquarters, now nearing completion for occupancy early in 1974. The Medical Sciences Building is being constructed on the grounds of Cincinnati General Hospital. Both college and hospital are major units in the UC Medical Center.

For a number of years the college has worked toward expanding numbers of doctors in training. By 1972 enrollment per class had been pushed to 120, the maximum possible in present quarters. Foreseeing the possibility of admitting more in larger facilities, the college planned and obtained support for the new \$50.7 million Medical Sciences Building. The State of Ohio has granted for the project \$17 million—UC, \$1.4 million, and the NIH Bureau of Health Professional Education and Manpower Training, \$32.3 million. (The latter is reportedly the largest construction grant ever given for medical education by the federal government).

At the June 3, 1973 commencement ceremonies, 110 seniors received doctor of medicine degrees. A few hours earlier at their honors day observance, they were addressed by Dr. Charles A. Hoffman, of Huntington, W. Va., a UC medical graduate who was completing his year's service as President of the American Medical Association.

Dr. Robert S. Daniels is interim dean of the College of Medicine. Dr. Edward A. Gall is vice-president of UC and Director of the Medical Center.



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President

MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals



# Lima Physician Is Installed as President of Ohio Academy of Family Physicians

David A. Barr, M.D., Lima, was installed as the 26th President of the Ohio Academy of Family Physicians on August 3 at the Columbus meeting. He succeeds Harry A. Killian, M.D., of Wiloughby.

The statewide 1700 member family physician organization held its annual scientific assembly at the Sheraton-Columbus Hotel. Governor John J. Gilligan had previously proclaimed the week of the meeting as Family Physician Week.

Other new officers installed were Drs. Carl E. Spragg, New Concord, as President-Elect; James C. Good, Columbus, as Vice-President; Lauren M. Brown, Akron, as Treasurer; Robert L. Reinhart, Columbus, as Speaker of House; Andreas S. Ahbel, Canton, as Vice-Speaker of House; B. Leslie Huffman Jr., Maumee, as national delegate; and H. Judson Reamy, Dover, as national alternate.

Newly elected directors are Drs. Kenneth A. Frederick, Cincinnati; Glen F. Aukerman, Jackson Center; Melvin Eckhouse, Maple Heights; A. John Antalis, Powhatan Point; Robert R. Johnson, Coshocton; Richard L. Counts, Chillicothe and James B. Patterson, Lorain.

During the Annual Banquet, David L. Steiner, M.D., Lima, was selected as the Thomas Rardin "GP of the Year" for his dedication and service to his community and his diligent pursuit of the prin-

ciples of family practice. Dr. John C. Wilke, Cincinnati, was given a special award for service in family life education. Nine members, who each have fifty years in medicine were honored. These are Drs. Gordon L. Erbaugh, Dayton; Norman E. Fisher, Toledo; Bernard J. Goldfarb, Cleveland; Sydney N. Lord, Somerset; William B. Malloy, Massillon; Howard R. Mitchell Sr., Columbus; Leo E. Stenger, Lancaster, George R. Wellwood, Barberton and William T. Wilkins, Piqua.

Executive offices of the OAFP are at 4075 N. High Street, Columbus 43214.

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An advanced continuing education workshop in "Plastic Surgery of the Nose: Rhinoplasty and Reconstruction" will be held September 29-October 3 at the University of Illinois Medical Center, Chicago. The course is jointly sponsored by the University's Department of Otolaryngology, the American Academy of Facial Plastic and Reconstructive Surgery, and Saint Joseph Hospital. Contact M. Eugene Tardy, Jr., M.D., Course Director, Eye and Ear Infirmary, 1855 W. Taylor Street, Chicago, Illinois 60612.



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# Bobo's back at the big top

After a rheumatoid arthritic flare-up.

**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hematology, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, especially those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Sublingual capsules for tablets if dyspeptic symptoms. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions, symptoms of blood dyscrasia, dyspepsia, epigastric symptoms of anemia, black or tarry stools or other signs of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Contraindications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Indications:** Children 14 years or less, senile patients with history or symptoms of G.I. inflammation or ulcers including severe, recurrent or persistent dyspepsia, history or presence of drug allergy, blood dyscrasias, renal, hepatic or cardiac dysfunction, hypertension; thyroid disease, systemic edema, arthritis and salivary gland enlargement due to the drug. Polymyalgia rheumatica and temporal arteritis, patients receiving other potent chemotherapeutic drugs or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, extent of concomitant diseases, and concurrent potent therapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use effective dosage. Weigh initially unpredictable against potential risk of severe, even fatal, reaction. The disease condition itself is unaltered by the use with caution in first trimester of pregnancy

## Butazolidin® alka Geigy

Each capsule contains:  
100 mg phenylbutazone USP  
100 mg dried aluminum hydroxide gel USP  
150 mg magnesium trisilicate USP

### If it doesn't work in a week, forget it.

and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals. Careful detailed history for disease being treated and detection of earliest signs of adverse reactions, complete physical examination including check of patient's weight, complete weekly (especially for the aging) or an every two week blood check, pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug, its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute

and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy, CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia, ulcerative stomatitis, salivary gland enlargement. (B)98-146-070-H(10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
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# More than sleep.

your choice of sleep medication  
is wisely based on more than  
sleep-inducing potential

## sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

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## sleep for 7 to 8 hours without need to repeat dosage

No sleep research has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.



sleep with  
consistency

Dalmane (flurazepam HCl) is a distinctive sleep medication—a diazepam specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other hypnotic.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, non-addictive agent proved effective and relatively safe for relief of insomnia.

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

# DALMANE<sup>®</sup>

(flurazepam HCl)

## When restful sleep is indicated

**One 30-mg capsule h.s. —usual adult dosage**  
(15 mg may suffice in some patients).

**One 15-mg capsule h.s. —initial dosage for elderly or debilitated patients.**

**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



ROCHE LABORATORIES  
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Nutley, New Jersey 07110

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*in study...after study...after study*<sup>1-6</sup>

Excellent/good results

**85%** in psoriasis  
(150 of 177 patients)<sup>1</sup>

**92%** in atopic eczema  
(231 of 251 patients)<sup>1</sup>

The image shows a stack of medical forms, likely from a clinical trial. The forms are titled 'CASE REPORT' and 'TOPICAL CORTICOSTEROID'. They contain various fields for patient information, including name, age, sex, and date of birth. There are also sections for 'DISEASE STATUS' and 'DURATION OF DISEASE'. The forms are filled out with handwritten and printed text, showing the results of the study. The forms are stacked on top of each other, with the top form being the most visible.



# Valisone<sup>®</sup>

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**96% in contact dermatitis**  
(81 of 84 patients)<sup>1</sup>

**References:** (1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Noojin, R. O.: *Curr. Therap. Res.* 9:253, 1967. (3) Falk, M. S.: *Cutis* 2:788, 1966. (4) Goldblum, R. W.: *Pennsylvania Med.* 69:50, 1966. (5) Niernan, M. M.: *J. Indiana M. A.* 10:1184, 1966. (6) Zimmerman, E. H.: *Arch. Dermat.* 95:514, 1967.



# ROCHE announces new **BACTRIM**<sup>TM</sup>

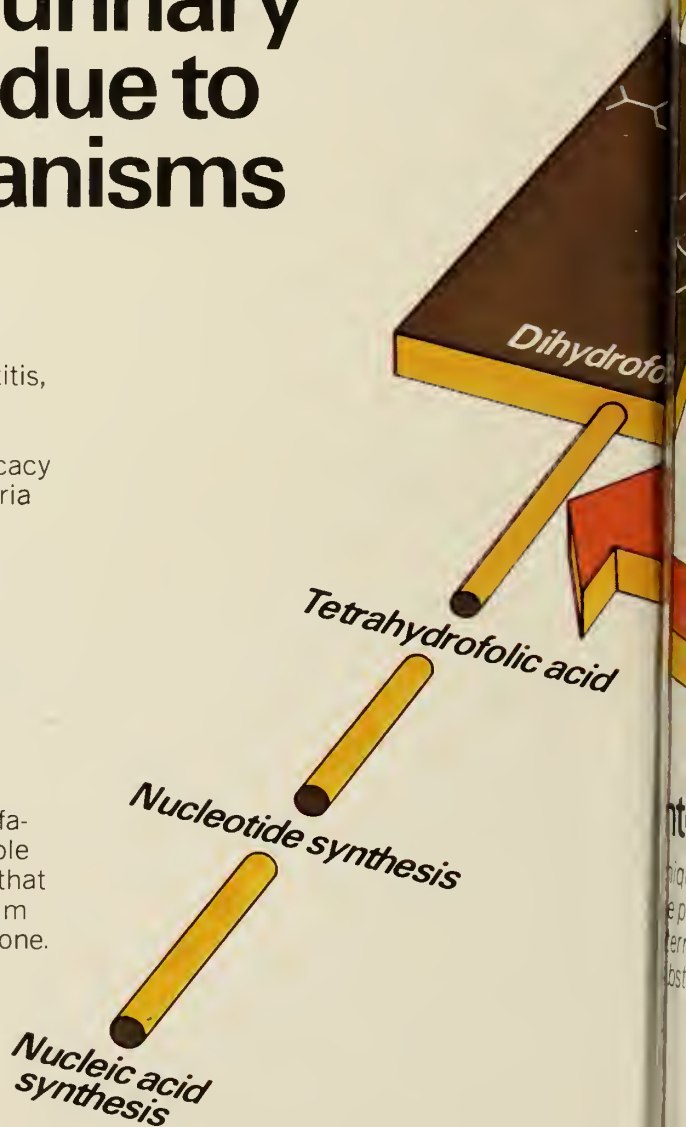
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

## a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

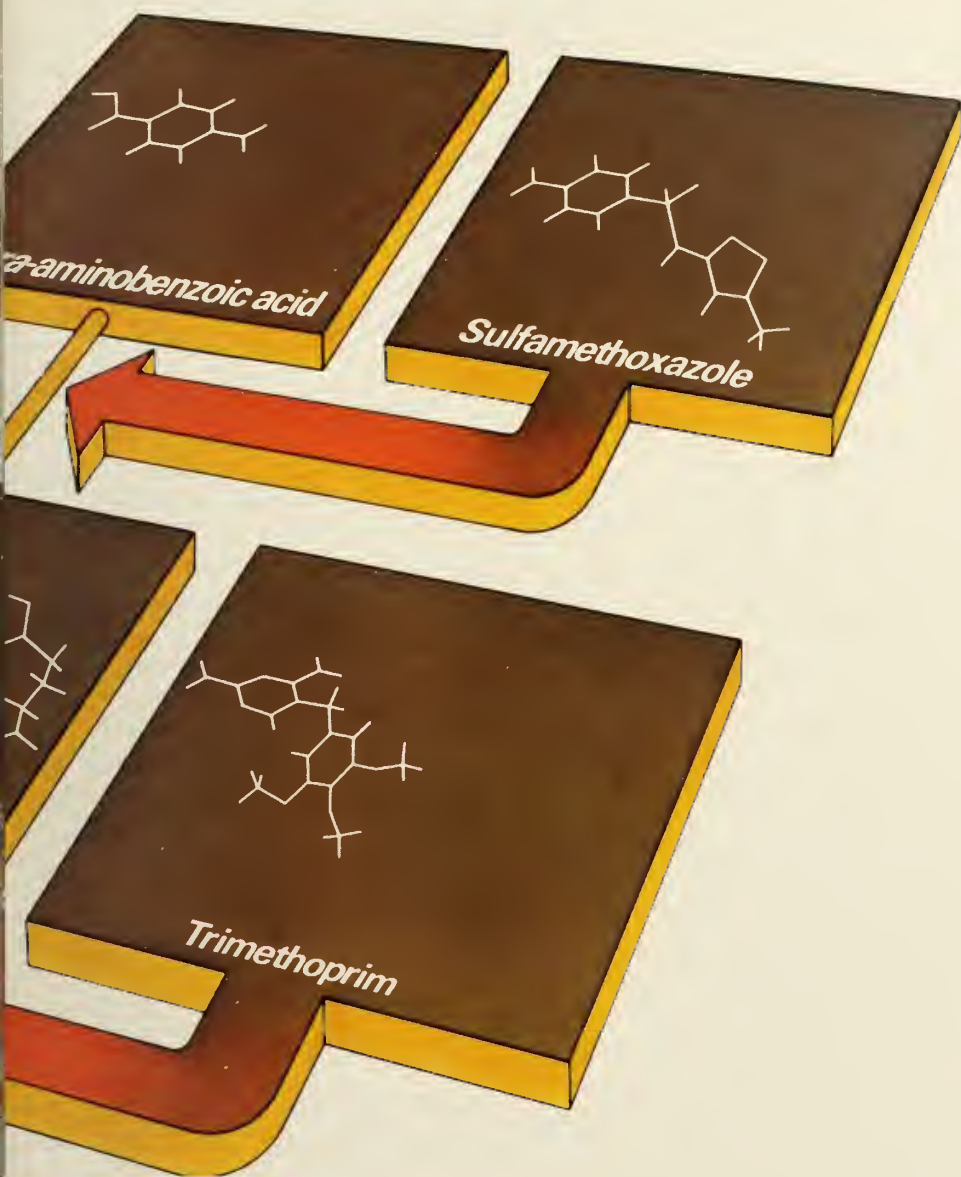
Bactrim is highly effective in the treatment of these infections — primarily pyelonephritis, pyelitis and cystitis, when due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species). This efficacy is related to the unique mode of action against bacteria (see opposite page), an action that, in effect, makes Bactrim a new type of antibacterial.

### Bactrim significantly superior to constituents in patients with obstructive complications

In the presence of obstructive uropathy, Bactrim has demonstrated efficacy which is superior to either sulfamethoxazole or trimethoprim alone against susceptible organisms. In addition, *in vitro*\* studies have shown that bacterial resistance develops more slowly with Bactrim than with either trimethoprim or sulfamethoxazole alone.



\*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.



ROCHE

## Interrupts life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.

new **BACTRIM**<sup>TM</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**

Before prescribing, please see complete product information on last page of advertisement.

## Excellent clinical response in chronic urinary tract infections

A multiclinic, double-blind study\* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. In patients with obstructive complications, 10th day response was 94.8% (of 97 patients) to Bactrim, 72.9% (of 85 patients) to trimethoprim and 58.5% (of 94 patients) to sulfamethoxazole.

## Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared

with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction—cases regarded as being notoriously difficult to treat.

## To date, low incidence of significant side effects

Although Bactrim demonstrated impressive clinical results, it is important to note that the incidence of clinically significant adverse effects was low, mainly nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

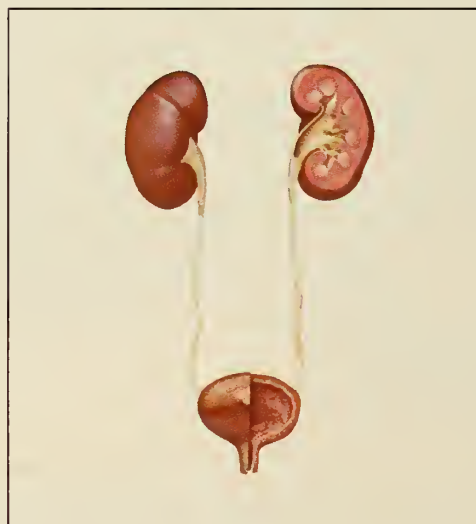
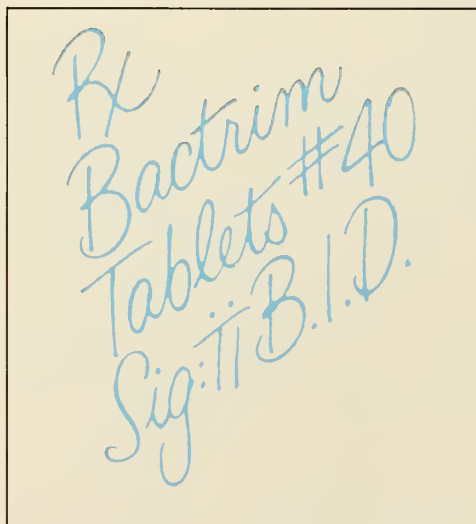
Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency and to those with severe allergy or bronchial asthma. Adequate fluid intake must be maintained. Complete blood counts, urinalyses with careful microscopic examination, and renal function tests should be performed during therapy.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.**

\* Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

† 4 patients not available for evaluation at day 10.



**new** **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**



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Division of Hoffmann-La Roche Inc  
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.



Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N<sup>1</sup>-(5-methyl-3-isoxazolyl)sulfanilamide. It is a almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

| Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml) |                    |                        |                |            |
|---|--------------------|------------------------|----------------|------------|
| Bacteria  | Trimethoprim alone | Sulfamethoxazole alone | TMP/SMX (1:20) |            |
|   |                    |                        | TMP            | SMX        |
| <i>Escherichia coli</i>   | 0.05—1.5           | 1.0 —245               | 0.05—0.5       | 0.95— 9.5  |
| <i>Proteus</i> spp.   | 0.5 —5.0           | 7.35 —300              | 0.05—1.5       | 0.95—28.5  |
| Indole positive <i>Proteus mirabilis</i>  | 0.5 —1.5           | 7.35 — 30              | 0.05—0.15      | 0.95— 2.85 |
| <i>Klebsiella-Enterobacter</i>  | 0.15—5.0           | 0.735—245              | 0.05—1.5       | 0.95—28.5  |

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. In repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma increases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration:** Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

| Creatinine Clearance (ml/min) | Recommended Dosage Regimen |
|-------------------------------|----------------------------|
| Above 30                      | Usual standard regimen     |
| 15-30                         | 2 tablets every 24 hours   |
| Below 15                      | Use not recommended        |

**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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## Scioto County Announces PG Courses for Oct. 11

The Scioto County Medical Society is sponsoring its fourth annual postgraduate medical seminar under the title of "Current Therapy IV—Supportive Care," on Thursday, October 11, beginning at 1:00 pm. and ending with a banquet and memorial lecture.

Following is a summary of the program. Additional information may be obtained from L. E. Thompson, Executive Secretary, 1805 27th Street, Portsmouth 45662.

Moderator: Sol Asch, M.D.

**Nutritional Tools for the Modern Physician—**Richard C. Bozian, M.D., professor of medicine and director of the Div. of Nutrition, University of Cincinnati.

**Respiratory Insufficiency—**Philip A. Bromberg, M.D., professor of medicine and director of the Pulmonary Disease Section, Ohio State University.

**Arrhythmia Analysis and Therapy in Myocardial Infarction —**Stephen F. Schaal, M.D., assistant professor of medicine, Division of Cardiology, Ohio State University.

**New Concepts in the Management of Shock —**John S. Vasko, M.D., professor of surgery, Division of Thoracic and Cardiovascular Surgery, Ohio State University.

**Approaches to Fluid Therapy and Water Balance—**Clark D. West, M.D., professor of medicine,

Dept. of Pediatrics, University of Cincinnati.

The cocktail period will begin at 6:00 p.m. with the banquet at 6:30. The *Dr. Ralph W. Lewis Memorial Lecture* will be given by Robert S. Daniels, M.D., professor and director of the Department of Psychiatry and Interim Dean of the College of Medicine, University of Cincinnati. His topic will be **The Individual Physician and the Medical Care Organization in Supportive Care.**

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## Grant Promotes Research on Spinal Cord Injuries

Experimental laboratory studies at Ohio State University of spinal cord injuries will try to determine why such injuries often cause permanent damage.

The studies are part of a five-year \$1,908,258 research project on spinal cord injuries under Ohio State's Division of Neurological Surgery. Through the grant, an Acute Spinal Cord Injury Research Center has been established at the University.

Ohio State is one of three medical centers in the nation to receive federal grants for such research from the National Institute of Neurological Diseases and Stroke of the National Institutes of Health.



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## Continuing Education Opportunities for Physicians in Ohio

### September

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106; Symposium on **Implementation of the Recommendations of the Secretary's Commission on Malpractice**, Sept. 6.

**Infertility**—Educational Forum cosponsored by the Cleveland Society of Obstetricians and Gynecologists, at the Cleveland Clinic, September 12, beginning at 3:00 p.m.; Nicholas Vorys, M.D., Dept. of OB-Gyn at Ohio State University, guest speaker; dinner and evening meeting, 7:00 p.m., Dr. Vorys to speak on **Hirsutism**. Contact Lester A. Ballard, Jr., M.D., at the Cleveland Clinic, 9500 Euclid Ave., Cleveland 44106.

**Tri-State Regional Meeting**, American College of Physicians, September 28-29, Salt Fork Lodge, Cambridge. For information, write William H. Bunn, Jr., M.D., 4025 Whippoorwill Way, Youngstown 44505. The Tri-State Region includes Ohio, Western Pennsylvania, and West Virginia.

### October

Colloquium on **The Range of Normal in Human Behavior**, at the Shriners Burns Institute Auditorium, Cincinnati, October 19-21; sponsored by the American Association for Social Psychiatry, the Department of Psychiatry, University of Cincinnati College of Medicine, and the Cincinnati Mental Health Institute; evening dinners planned. Contact Robert S. Daniels, M.D., Department of Psychiatry, University of Cincinnati Medical Center, 234 Goodman Street, Cincinnati 45229.

**Cleveland Clinic Educational Foundation**, 9500 Euclid Ave., Cleveland 44106; **Dermatology for the Non-Dermatologist**, Oct. 10-11; **Current Status in Artificial Organs**, Oct. 19-20; **Pediatric Endocrinology**, Oct. 24-25.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

**Northwestern Ohio Medical Association**, annual meeting and scientific session, Holiday Inn, Bowling Green, Oct. 31; 10:00 a.m. to 4:00 p.m.; contact Marjorie E. Conrad, M.D., president and chairman, 15819 Bowling Green Road West, Bowling Green 43402.

### November

**Occupational Medicine and Environmental Health**—2-week full-time course with emphasis on clinical and environmental hygiene problems, coverage of OSHA; November 5 to November 16; tuition \$600; for details contact Sidney Lerner, M.D., Kettering Laboratory, Department of Environmental Health, College of Medicine, University of Cincinnati, Cincinnati, Ohio 45219.

**Toxemia of Pregnancy**—Educational Forum sponsored by the Cleveland Society of Obstetricians and Gynecologists, at the Marriott Inn, 4277 W. 150th Street, Cleveland, November 14, beginning at 3:00 p.m.; guest speaker, Russell DeAlvarez, M.D., Temple University; dinner and evening meeting, 7:00 p.m. with Dr. DeAlvarez continuing the discussion on the same subject. Contact Lester A. Ballard, Jr., M.D., Secretary, Clinic Center, 9500 Euclid Avenue, Cleveland 44106.

**Gastroenterology**—Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; November 14-15.



# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."



# **M-M-R<sup>\*</sup>**

## **(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)**

Single-dose vials

**M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.**

### **MSD suggested immunization schedule for well babies**

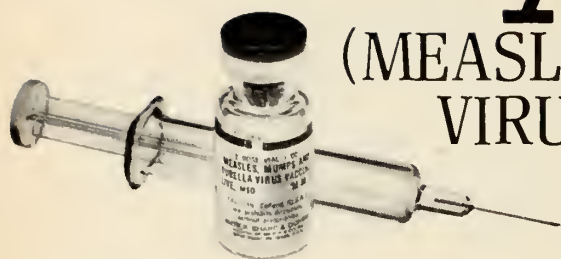
| <b>Age</b>       | <b>Vaccine(s)</b>   |
|------------------|---|
| 2 months         | DPT (diphtheria-pertussis-tetanus)<br>Oral poliomyelitis vaccine (triple) |
| 3 months         | DPT <sup>1</sup>  |
| 4 months         | DPT<br>Oral poliomyelitis vaccine (triple)                                |
| 6 months         | Oral poliomyelitis vaccine (triple)                                       |
| <b>12 MONTHS</b> | <b>M-M-R (MEASLES, MUMPS AND<br/>RUBELLA VIRUS VACCINE, LIVE, MSD)</b>    |

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

<sup>\*</sup>Trademark of Merck & Co., Inc.

**For a brief summary of prescribing information, please see following page.**



# M-M-R

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

**Contraindications:** Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

**Precautions:** Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

**Adverse Reactions:** Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

**How Supplied:** Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID<sub>50</sub> (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID<sub>50</sub> of mumps virus vaccine, live, and 1,000 TCID<sub>50</sub> of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

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# Obituaries

**Solomon Bertram Abrams, M.D.,** Cleveland; New York University School of Medicine, 1918; aged 77; died July 10; member of OSMA, AMA, and the American Physicians Fellowship; diplomate, American Board of Obstetrics and Gynecology; native of Cleveland and practitioner for some 54 years there.

**John Evans Allgood, M.D.,** New Middletown; Eclectic Medical College, Cincinnati, 1937; aged 64; died July 20; member of OSMA and AMA; general practitioner in the Mahoning County community for virtually all of his professional career.

**Joseph Edward Brown, M.D.,** Cleveland; Leonard Medical School, Raleigh, N.C., 1913; aged 86; died June 27; member of OSMA, AMA, and American Academy of Family Physicians; practitioner in Cleveland since 1943; previously practiced for about 30 years in Keystone, W. Va.

**Paul Trowbridge Carroll, M.D.,** Columbus; University of Cincinnati College of Medicine, 1946; aged 52; died July 24; member OSMA, AMA, and the American Proctologic Society; fellow, American College of Surgeons and the International College of Surgeons; diplomate, American Board of Colon and Rectal Surgery; practicing physician and surgeon in Columbus for a number of years; formerly served in the Navy Medical Corps.

**Leon Haskins Dembo, M.D.,** Cleveland and Chagrin Falls; Jefferson Medical College of Philadelphia, 1920; aged 77; died July 14; member of OSMA and the American Academy of Pediatrics; diplomate, American Board of Pediatrics; practitioner in the Cleveland area for many years, specializing in pediatrics; former editor of the Cleveland Academy *Bulletin* and author of a humorous column in the *Bulletin*.

**William Burton Epps, M.D.,** Massillon; Western Reserve University School of Medicine, 1951; aged 53; died July 18 while in the Virgin Islands; practitioner in Massillon since 1954; served as a Naval aviator during World War II and in the Navy Medical Corps during the Korean Conflict.

**Arthur Gorman Hills, M.D.,** Toledo; Johns Hopkins University School of Medicine, 1942; aged 58; died June 19; recently joined the faculty of the Medical College of Ohio at Toledo as professor in the Department of Physiology, coming to Ohio from Miami, Florida.

**William Arnett Morton, M.D.,** Wooster; University of Cincinnati College of Medicine, 1923; aged 79; died July 9; former member of OSMA; practitioner in Wooster until the 1950s, specializing in the EENT field. He later was engaged in a private business enterprise.

**Thomas Eastman Mueller, M.D.,** Cleveland; Temple University School of Medicine, 1967; aged 32; died July 8; associated for about five years with the Kaiser Community Health Foundation in Cleveland.

**James Eugene Schaal, M.D.,** Maumee and Toledo; St. Louis University School of Medicine, 1929; aged 68; died July 15; former member of OSMA; native of Toledo and practitioner of long standing in that vicinity.

**Carroll Lee Sines, M.D.,** Nelsonville; Western Reserve University School of Medicine, 1952; aged 51; died July 4; member of OSMA and AMA; general practitioner in the Nelsonville area since 1955.

**William Charles Stahl, M.D.,** Columbus; Washington University School of Medicine, 1941; aged 61; died June 23; retired recently after serving for a number of years as physician for the Ohio Industrial Commission.

**Josephine Dirion - Phillips Stalley, M.D.,** Cleveland; Ohio State University College of Medicine, 1930; aged 81; died July 15; member of OSMA, AMA, and American Academy of Ophthalmology and Otolaryngology; diplomate, American Board of Ophthalmology; practitioner of long standing in Cleveland and chief of ophthalmology at Huron Road Hospital from 1945 to 1962.

**Neven Perry Stauffer, M.D.,** Millersburg; Western Reserve University School of Medicine, 1928; aged 72; died July 15; former member of OSMA; practitioner in Millersburg from 1946 to 1971 when he retired; previously practiced in Toledo and in Killbuck.

**Claire Edwin Stout, M.D.,** West Milton; Hahnemann Medical College of Philadelphia, 1939; aged 63; died July 24; member of OSMA and AMA; general practitioner in the West Milton and Dayton area for most of his professional career.

(Continued on Page 667)



## Obituaries (Contd.)

Clifford Francis Stuhlmueller, M.D., Hamilton; St. Louis University School of Medicine, 1922; aged 77; died July 20; member of OSMA and AMA; retired in recent years after a general practice of long standing in the Hamilton area.

Alvin Szojchet, M.D., Canton; Georgetown University School of Medicine, 1958; aged 41; died July 6; member of OSMA, AMA, and the Congress of Neurological Surgeons; practitioner in Canton since 1967, specializing in neurosurgery; served in the U.S. Navy Medical Corps from 1959 to 1962.

Douglas Lorne Thomson, M.D., Marion; McGill University Faculty of Medicine, Canada, 1954; aged 42; died July 22; member of OSMA, AMA, and the Association of Life Insurance Medical Directors of America; Fellow, American College of Physicians; practitioner in Marion for about three years, specializing in internal medicine; previously assistant professor of medicine and head of Division of Gastroenterology at McGill University.

## MDs in the News

Dr. Thomas Hale Ham, professor of medicine at Case Western Reserve University School of Medicine, was one of two recipients of the 1973 Distinguished Teacher Award of the American College of Physicians. A pioneer in the revision of medical education, he was especially cited for his part in updating teaching programs at CWRU.

Governor John J. Gilligan recently announced appointment of Dr. William C. Seiler, of Sandusky, as a trustee of the Soldiers' and Sailors' Home in Sandusky. The appointment is for a five-year term and he succeeds Dr. Peter A. Volpe, of Columbus, whose term had expired.

Dr. Bertha M. Joseph, of Martins Ferry, was honored at a recent meeting of the Belmont County Medical Society and cited for her contributions to the Society as secretary-treasurer for 22 years.

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VOLUME 69

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NUMBER 9

# Polymyalgia Rheumatica

## A Review of Recent Literature

STEVEN FELD KANTER, M.D.

AT A CONFERENCE on Polymyalgia Rheumatica and Giant Cell Arteritis in April 1970 at the Mason Clinic in Seattle, Washington, polymyalgia rheumatica was defined as: "a syndrome of older patients, characterized by pain and stiffness of the shoulder or pelvic girdle muscles, without weakness or atrophy; these symptoms persist for at least a month, with a sedimentation rate of greater than 50 mm/hour, and dramatic relief of symptoms with the use of steroids."<sup>1</sup>

The condition has many synonyms including: senile rheumatic gout, secondary fibrositis, periarthrosis humeroscapularis, peri-extra-articular rheumatism, myalgic syndrome of the elderly with systemic reaction, pseudopolyarthrite rhizomélisque, anarthritic rheumatoid disease, rhizomelic inflammatory rheumatism of the aged, and polymyalgia arteritica.<sup>2</sup>

### Epidemiology

Polymyalgia rheumatica is most common after ages 55 to 60 years (range of the age on onset is 31 to 83 years with the average age about 65), and it is found in females approximately 2:1

### *The Author*

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over males. There seems to be a predilection for Caucasians and upper socioeconomic groups and also a seasonal variation in incidence, but none of these has been validated. One investigator reported that 15 of 28 patients with polymyalgia rheumatica had had significant contact with birds (especially with parakeets).<sup>1</sup>

### Clinical Picture

Patients are usually in good general health and leading fairly active, normal lives prior to the onset of polymyalgia rheumatica. Onset can be abrupt or insidious, developing over a month or two. The shoulder girdle and neck muscles are the most frequent areas involved with severe pain

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and stiffness. The hip girdle and lumbar, spinal, and thigh muscles are also commonly involved. The pain persists for at least one month, is more often present with motion, and is muscular (not tendinous or articular). Morning stiffness is variable, but often is marked and mimics that of rheumatoid arthritis. Muscle weakness is not a prominent feature and, when present, is usually secondary to pain rather than to true loss of muscle strength. Muscles may be affected in a symmetrical fashion.

Transient joint swelling due to synovitis may occur, especially in the knees and sternoclavicular joints. Fingers, wrists, hands, the acromioclavicular joints, and shoulders also have been reported as having transient swelling.<sup>2</sup> Limitation of motion of joints may develop.

Systemic signs are common and often appear in the first week of the disease. These include a low-grade fever (or rarely a high-grade fever), night sweats, anorexia, weight loss, lassitude, general depression, and abdominal discomfort.

If the patient has the associated condition of cranial arteritis, additional clinical features may be found. Common signs are temporal headaches, painful temporal arteries, loss of vision, intermittent claudication, pain in the jaw muscles when chewing, fever of unknown origin, and hypoproliferative anemia responding to steroids.<sup>1</sup> Also, bruits may be heard over the carotid, subclavian, axillary, brachial, femoral, or popliteal arteries.<sup>2</sup>

### Diagnostic Studies

An accelerated erythrocyte sedimentation rate is a *sine qua non* for diagnosis and should be at least 50 mm per hour.<sup>1</sup> More often it is much higher, often reading 100 mm per hour. It should be noted, however, that Bruk<sup>3</sup> in his series of 80 patients included five with a normal sedimentation rate. Bruk also noted that the sedimentation rate is higher in patients with associated arteritis than in those who do not have arteritis (means: 79 mm versus 53 mm). Fauchald, et al<sup>4</sup> also noted this but to a lesser degree (means: 107.4 mm versus 99.7 mm). The sedimentation rate usually decreases with a decrease in pain and stiffness, but remains greater than normal during the course of the disease. Corticosteroids usually reduce the sedimentation rate to normal.

A mild hypochromic or normochromic anemia is commonly found. Leukocytes are usually normal although occasionally there is found a slight leukocytosis and/or eosinophilia.

Plasma protein abnormalities are common, but no diagnostic pattern has been found. There may be a decrease in albumin with an increase in alpha<sub>1</sub>, alpha<sub>2</sub>, and gamma globulins. Increase in

fibrinogen and the presence of cryoglobulins have been reported.<sup>2</sup>

Nearly all patients are negative for LE cells, rheumatoid factor, and antinuclear antibody elevations. Serum enzymes, including creatine kinase, phosphokinase, glutamic oxaloacetic transaminase, and aldolase are normal.

Articular roentgenograms are not diagnostic, either being normal or showing degenerative arthritis compatible with the patient's age. Synovial biopsy, done in a few instances, has shown non-specific changes of inflammation. Muscle biopsy and electromyography are normal or nonspecific. Data on synovial fluid analysis are incomplete.

Temporal artery biopsy is used to detect arteritis and has been positive in from zero to 78 percent of patients. Hunder, et al<sup>2</sup> felt the average to be around 20 percent. More recently, Fauchald, et al<sup>4</sup> reported a positive biopsy in 61 of 94 (65 percent) patients with polymyalgia rheumatica, and they cautioned that a negative biopsy does not rule out temporal arteritis because of the segmental dissemination of the arteritis and the small part of the artery that undergoes histologic examination. (Four of their 33 patients, or 12 percent, had a negative biopsy with clinical temporal arteritis.) They further reported that 36 of 40 (90 percent) patients with local symptoms of temporal arteritis had a positive biopsy while 20 of 49 (40 percent) patients without local symptoms had a positive biopsy. Healey, et al<sup>1</sup> feel that temporal artery biopsy is indicated in all patients with polymyalgia rheumatica who are over 50 years old and who have a marked systemic reaction, even though there is no history of headaches and no definite cranial artery abnormality noted. Fernandez-Herlihy<sup>5</sup> suggests that biopsy is not obligatory, but that careful follow-up of the patient with special attention paid to any development of symptoms related to cranial arteritis (especially visual disturbances, scalp tenderness, or pain in the masseter muscles while chewing) is a necessity.

### Associated Conditions

The most common associated condition is the syndrome of giant cell arteritis of which temporal arteritis is only a part, according to many. It is diagnosed in up to 65 percent of polymyalgia rheumatica patients, and some believe that polymyalgia rheumatica is just one manifestation of giant cell arteritis.<sup>6</sup> Many feel the same disease process, a generalized vasculitis, is the underlying mechanism for both conditions. It is very important that this condition be recognized because of the danger that the patient may develop a major vascular accident, such as blindness, stroke, coro-



nary occlusion, or dissecting aneurysm. Fernandez-Herlihy<sup>5</sup> reported a 15 percent risk of visual impairment in patients with polymyalgia rheumatica unless there was evidence of giant cell arteritis, in which case the risk increased to 53 percent. (However, Fauchald, et al reported their figures to be 5.3 percent and 7.5 percent, respectively.)

Other diseases which may complicate or cause symptoms like polymyalgia rheumatica are: Sjögren's syndrome; rheumatoid arthritis; atherosclerosis; lymphoma, multiple myeloma, other neoplasms, and leukemia; systemic lupus erythematosus; infectious disorders, especially chronic granulomatous diseases such as tuberculosis and histoplasmosis, but also virus and flu-like syndromes; any intrinsic diseases of muscles or their innervations; and degenerative processes associated with aging.<sup>1-3,6</sup>

### Treatment

The treatment of choice for polymyalgia rheumatica is corticosteroid. There is no unanimity of opinion on dosages.

Healey, et al,<sup>1</sup> use corticosteroids in their diagnostic criteria for polymyalgia rheumatica: "... subjective relief of pain and stiffness within four days so that as little as 10 mg of prednisone (or equivalent)/day is needed." They reported from their conference that some physicians favor initially high doses (40 mg prednisone/day) with rapid tapering, while others favor initially low doses (10 mg prednisone/day). They feel that most patients will require a maintenance dose (average 7.5 mg prednisone/day) for at least one to two years and that usually after two years the dose may be withdrawn, but it may be necessary to continue longer.

Fernandez-Herlihy<sup>5</sup> uses two different dosage regimens, depending on whether or not overt evidence of giant cell arteritis is present (tender cranial arteries, pain in masseter muscles upon chewing, unexplained visual disturbances, or unexplained peripheral arterial occlusions). Without overt evidence of giant cell arteritis, he uses prednisone, 10 mg orally once daily (preferably at bedtime). He states that relief of symptoms should be seen within one week and the erythrocyte sedimentation rate should return to normal in two to three weeks. With overt signs of giant cell arteritis, he uses prednisone, 40 to 60 mg, orally once daily for seven to ten days with a gradual reduction to a maintenance dose of 10 to 20 mg daily. He also suggests that reduction of the maintenance dosages in either regimen should be tried every two to three months, and that usually the prednisone can be withdrawn gradually after two to

three years with the disease at its apparent end. If signs and symptoms recur, and the sedimentation rate rises, he suggests that the maintenance dose should be given for another two to three months and then tapered off again.

Although corticosteroids give subjective relief of pain and stiffness within a week, there is no evidence that steroids shorten the course of the disease.

Of course, before steroids are given, it should be established that the patient has primary polymyalgia rheumatica (tumor, collagen vascular disease, etc. having been ruled out).

Salicylates, phenylbutazone (200 to 600 mg daily), oxyphenbutazone, indomethacin (25 mg two to four times daily), chloroquine and hydroxychloroquine (400 to 600 mg daily), and gold salts have all been tried and have given variable results.<sup>2</sup>

Bed rest and physical therapy are also indicated in some instances.

### Course

When polymyalgia rheumatica is not associated with any other recognized condition, the prognosis is good. The active disease may last from a few months to four years or more, with exacerbations and remissions. Eventual spontaneous recovery is the rule, even without corticosteroid treatment.<sup>6</sup> Relapses are usually due either to an early discontinuation of steroids or to too sudden or rapid a reduction in the dosage of steroids but may occur even after two years of adequate treatment. Recurrences are uncommon.

When polymyalgia rheumatica is associated with giant cell arteritis, complications can be severe resulting in a major vascular accident as previously mentioned.

**Acknowledgment:** I am grateful to Dr. Norman O. Rothermich for his encouragement, assistance, constructive criticism, and the reading of this paper.

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# Hair Strangulation of the External Genitalia

## Report of Two Cases

JACK L. SUMMERS, M.D., AND ALEXANDER C. GUIRA, M.D.

**T**HE FIRST CASE REPORT is prompted by the unusual finding of a nearly complete amputation of the distal two-thirds of the glans penis by the unintentional entanglement of the patient's own hair about the glans penis.

The second case is an unusual strangulation of the labia majora by hair entanglement.

### Case Reports

**Case 1.** A 2-year-old white boy was brought to the emergency room when his parents discovered on a diaper change that the end of the penis was nearly severed, appeared to be hanging by a slender stalk, and that something appeared to be tied around the penis (Fig. 1).

Both parents worked, and the patient was cared for by a baby-sitter. The patient had not had any symptoms or complaints referable to the penis. There had been no dysuria, and no blood had been noted on the diapers. He had been totally asymptomatic.

Physical findings were localized to the penis. Several small thread-like structures, the color and consistency of the patient's hair were found matted about the penis in a constricting fashion one centimeter distal to the coronal sulcus of the glands and cutting circumferentially through the entire penis with the exception of the dorsal one-third of the urethra and a small column of the right corpus cavernosum penis (Fig. 2). There was no bleeding, no infection, and very little tissue reaction along the cut margins. The distal glans was pink and viable and bled freely on needle puncture.

Under general anesthesia, the foreign body was removed and identified by the pathologist as human hair. There were several strands of hair, and no intentional knotting could be found, only multiple intertwined random knots were observed. A splinting catheter was placed across the severed urethra from the urethral meatus, and the urethra was reapproximated with 5 to 0 chromic catgut. With 4 to 0 chromic gut, the amputated glans was reconstructed with deep, verticle, mattress sutures. The splinting catheter was left indwelling for three weeks and removed.

It appeared at first as though the repair might not hold, when a few scattered areas broke down super-

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ficially. However, the deep layer held, and the wound closed secondarily during the next four months. The urethral repair had a small lateral fistula postoperatively, but this likewise closed.

**Case 2.** An 11-year-old white girl presented at the office complaining of severe pain in the region of the right labia majora for several hours. Inspection of the area revealed several hairs twisted in a random fashion about a swollen, red hillock of labia, producing a strangulation lesion. The hair was removed in the office, and there was no permanent injury. No further therapy was necessary.

### Discussion

Pediatricians are well aware of the dangers concerned with hair wrapping in infants. The loss of fingers and toes, even in well-staffed nurseries, by the accidental entwining of hair about an intact appendage is documented.<sup>1</sup> One other case of hair wrapping about the penis was found in the literature.<sup>1</sup> The wrapping of hair about the appendages to ward off evil spirits is a custom of some ethnic groups like the gypsies.<sup>1-5</sup> However, the wrapping usually is accidental.

Hair is thin, has great tensile strength, measured in our laboratory as 29,000 pounds per square inch (according to an oral communication in Feb-

Submitted March 21, 1973.



FIG. 1. Penis showing entangled hair.



FIG. 2. Ventral surface of penis demonstrating severed urethra.

ruary 1972 from J. L. Potter, M.D.), and constricts when drying out, making it an excellent agent for accidental or intentional constriction. Being quite fine, it easily goes undetected if hidden in a groove or skin fold.

In case 1, however, the lesion was in a circumcised glans, and detection of the lesion at an earlier stage seems possible.

That the glans penis survived could only be explained by the fact that the bulbo-urethral artery, which traverses the corpus spongiosum penis, must have been contained in the undamaged dorsal wall of the urethra or pursued an aberrant course through the small tongue of the remaining corpus cavernosum penis.

If the distal structures seem at all viable, obviously every attempt at primary repair would be the therapy of choice in these cases.

The pain exhibited in case 2 would seem to be the more expected presenting complaint, and treatment would be more successful.

### Summary

Two cases of unintentional strangulation of the external genitalia by human hair, are presented as urologic curiosities, and to alert urologists to this possibility.

Primary repair of all salvagable tissue is the obvious treatment of choice.

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## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

A 65-year-old man presents with persistent epistaxis from his left nares for the past week. Several attempts at nasal packing were unsuccessful

until you placed a posteroanterior nasal pack which controlled the bleeding.

The packing was removed two days ago and his nose has remained dry. What follow-up is indicated and when?

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Submitted May 8, 1973.

(See p. 678 of this issue for further information and discussion.)



# Use of Ultrasound in Ophthalmology

## Report of Six Cases

FRANK J. WEINSTOCK, M.D., and ALEXANDER KOVAC, M.D.

THE APPLICATION OF ULTRASOUND in diagnosis of certain diseases has proved its value in the past few years. Many fields in medicine have accepted ultrasound examination as part of routine procedure and fruitful results have been obtained. From the first use of ultrasound to determine shifts of the brain midline,<sup>1</sup> abnormalities of the mitral valve<sup>2,3</sup> or presence of pericardial effusion,<sup>4</sup> the field has expanded considerably in the same areas (neurology, neurosurgery, and cardiology) and to other fields and organs. Evaluation of aortic and tricuspid valves in cases of stenosis or incompetence,<sup>5-7</sup> placenta praevia,<sup>8</sup> determination of fetal weight prior to delivery by measuring the biparietal diameter of the fetal skull,<sup>9</sup> detection of tumors and hepatic lesions, and many other uses have been described.

Excellent results are also obtained in ophthalmology, especially if and when other methods have failed or cannot be applied. This is true in borderline cases or when a combination of diseases occur concomitantly. When cataracts, corneal or vitreous opacities, or hyphema prevent visualization of the fundus of the eye, evaluation of the retina for the presence or absence of retinal detachment, tumors, or foreign bodies may easily be performed by ultrasound, often yielding excellent results. The whole procedure is completely painless and harmless to the individual. It requires a minimum of time and can be repeated at will and periodically.

Ultrasound means acoustic energy beyond the sensitivity range of the human ear (above 20,000

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cycles per second) and is produced by certain crystalline or ceramic substances, which oscillate when electric energy is passed through them, (piezoelectric property). If the electric energy is made to fluctuate rapidly, the crystal will change size rapidly and produce a pulsating beam of ultrasonic energy. This beam, as it passes through tissues, will produce different deflections, according to the tissue property and is called acoustic impedance. This is, in turn, a product of speed in tissue times the density of the tissue:

$$Z = pV$$

The crystal or transducer serves as sender and receiver at the same time. The returning mechanical energy deforms the crystal and produces electrical current which is measured and recorded on an oscilloscope. Further recording is made on self-developing film (Polaroid®), magnetic tape, or by other appropriate methods.

Ultrasonic information obtained is displayed on the oscilloscope by a series of peaks (Fig. 1), where the intensity of returning echoes is represented by the amplitude of each peak (A-mode = amplitude modulation). If the same peaks are being viewed on end (by mechanically reversing

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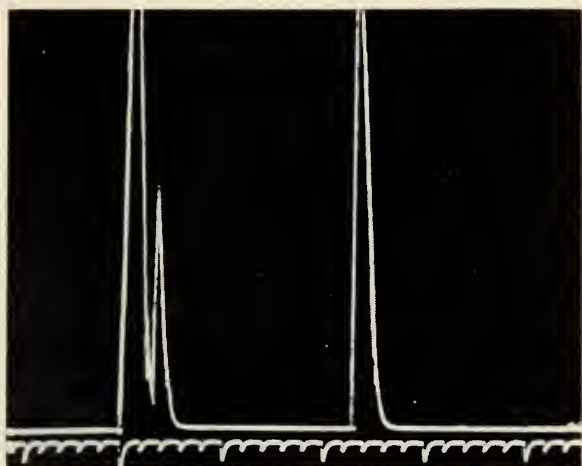


FIG. 1. Normal A-mode sonogram of eye. Space without deflections represents corpus vitreous.

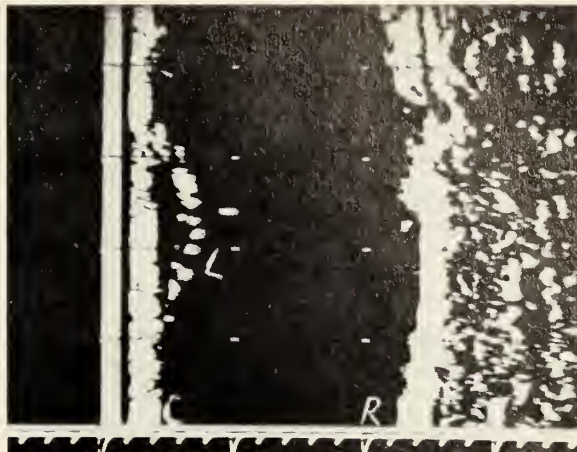


FIG. 2. B-mode examination of normal eye. Note visualization of posterior surface of lens (L) and point of entry of optic nerve. C=cornea. R=retina.

the peaks on the oscilloscope) a series of dots will be seen (Fig. 2); their brightness indicative of the intensity of returning echoes (B-mode or brightness modulation). If the dots obtained in B-mode are being swept mechanically across the screen of the oscilloscope, especially when examining or viewing tissue or organs in motion, a curvilinear pattern is obtained. (M-mode = motion mode.)

### Technic

The equipment used is an A- and B-mode combination produced by Hoffrel Instruments, Inc. with a special eye transducer of 7.5 megahertz. The machine is kept in the radiology department of the hospital but can easily be wheeled elsewhere if desired. The patient does not require any premedication or local anesthesia since the procedure is completely painless. The examination can be performed either in the sitting or recumbent position

(Figs. 3 and 4). All of our patients were sitting comfortably in a chair with the head slightly deflexed. Except for case 2, topical anesthetic drops were used.

Although the examination can be performed by the radiologist or ophthalmologist alone, best results are obtained when they see the patient together.

### Case Reports

**Case 1.** R.O. is a 16-month-old male, who had been in low concentration oxygen for five weeks after birth. Eye examination showed small corneas, shallow anterior chambers, and dense bilateral cataracts. Cataract surgery was being considered. Ultrasound examination showed many abnormal echoes in the vitreous and multiple echoes of the posterior wall, indicating retinal detachment and retrolental fibroplasia. Cataract surgery was not indicated, and it was possible to give the parents an accurate diagnosis and prognosis and to avoid surgery, which would have caused needless discomfort and expense to the patient and his family (Figs. 5 and 6).

**Case 2.** W. N., A 52-year-old man, was working with a chisel in a mine six months earlier and felt "something hit the eye." The original x-ray films

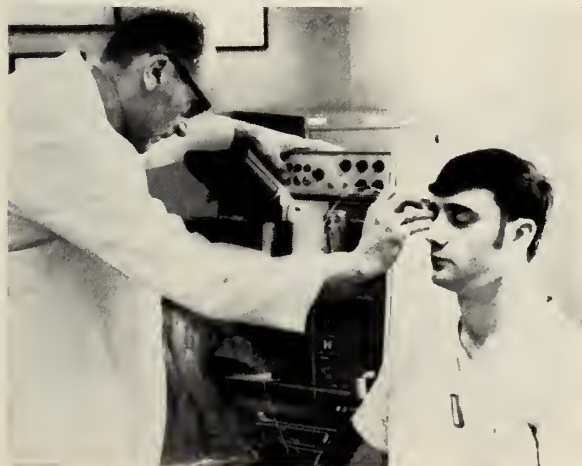


FIG. 3. Position of patient during the examination.



FIG. 4. Close-up of position of transducer.



described a radiopaque foreign body which had traversed the globe and was resting posterior to it.

When the patient was first seen several months after the injury, vision in the affected eye was decreased to finger counting, but no details of the fundus could be seen owing to a dense traumatic cataract. Repeat x-ray films showed a foreign body within the eye globe. A-mode ultrasound examination localized the foreign body within the globe 13 mm posterior to the limbus at 5:30 position near the retina. There was no evidence of retinal detachment. Incision over the site determined by the ultrasound allowed direct, simple, uncomplicated removal of the foreign body with the magnet (Fig. 7).

Case 3. L. F. is a 63-year-old woman who had lost vision in her left eye after surgery elsewhere for angle-closure glaucoma. The right eye had a dense cataract and almost no anterior chamber. She had been told not to have cataract surgery due to the fact that she may have retinal detachment or recurrent vitreous hemorrhages. Because of her inability to function normally, she wanted to have cataract surgery performed. Ultrasound examination failed to show evidence of retinal detachment or any vitreous hemorrhage, thus indicating a good prognosis. Uneventful cataract surgery was performed with result-

ing 20/25 vision. Clear vitreous and a flat retina were seen and maintained (Fig. 8).

Case 4. L. S. is a 53-year-old woman with a history of six months of progressive decrease of vision in the left eye. An elevated lesion of the fundus was seen with the ophthalmoscope. It was felt to be a solid mass by clinical examination, although two of three consultants did not feel it was a tumor. Ultrasound examination showed abnormal echoes situated posteriorly. Enucleation was performed and microscopic examination confirmed the presence of malignant melanoma (Fig. 9).

Case 5. G. H. is a 47-year-old man, who fell in the bathtub sustaining extensive trauma to the right eye and orbit. There was evidence of retrobulbar hemorrhage

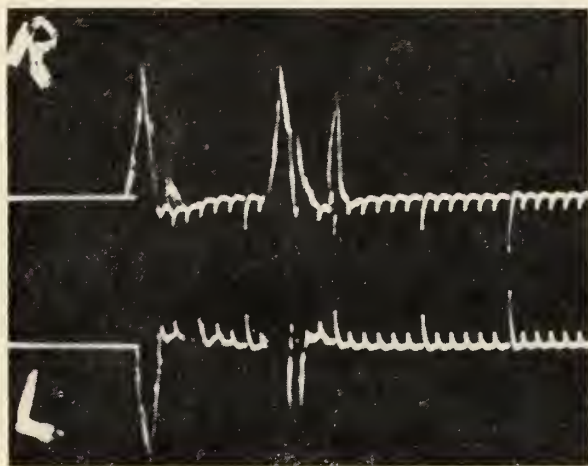


FIG. 5. (Case 1.) Comparative A-mode sonogram of right and left eye. Difference in size is noticeable (L=18 mm, R=22 mm). Multiple echoes in corpus vitreous, especially in left eye.

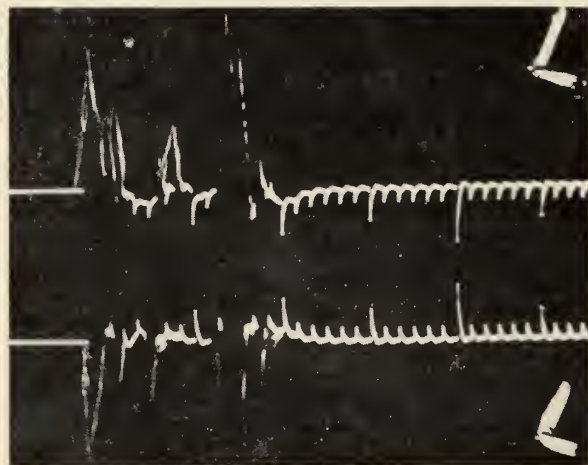


FIG. 6. (Case 1.) Left eye. Abnormal echoes are noted in vitreous.

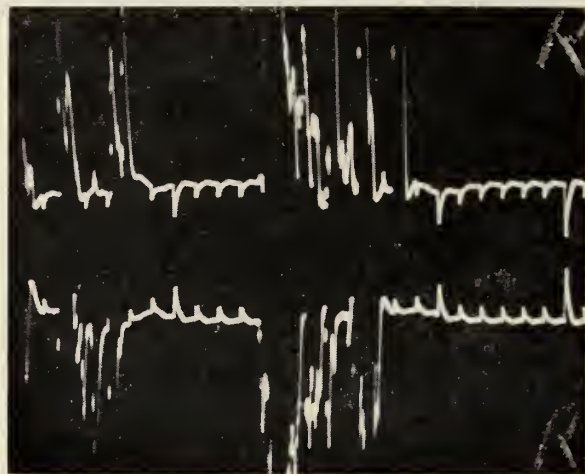


FIG. 7. (Case 2.) Abnormal echoes representing foreign body and blood within globe.

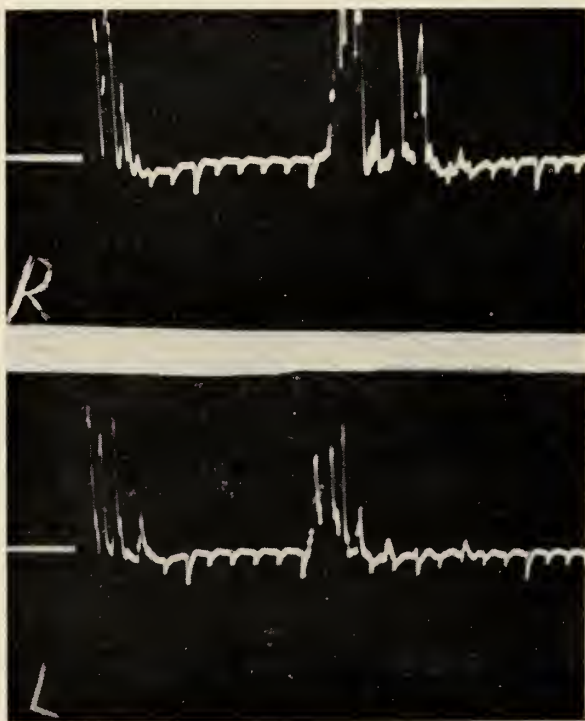


FIG. 8. (Case 3.) A-mode sonograms of both eyes. No evidence of retinal detachment in right eye. Shallow anterior chamber of left eye.



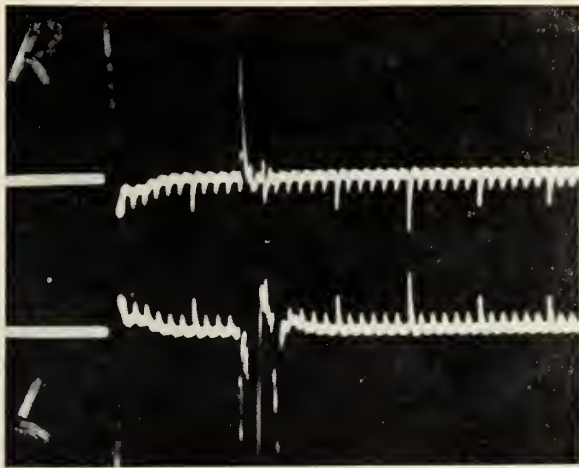


FIG. 9. (Case 4.) Abnormal echoes in posterior portion of left eye adjacent and confluent with retina. Malignant melanoma confirmed by surgery.

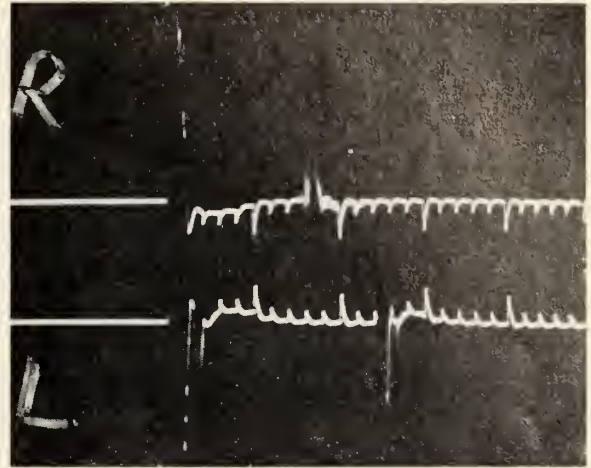


FIG. 10. (Case 6.) Marked discrepancy in size of eyes (R=20 mm, L=25 mm). Retinal detachment on right—16 mm from corneal surface. No abnormal echoes within left eye.

and hyphema. Owing to loss of light perception and inability to examine the fundus of the eye, ultrasound examination was performed to determine the extent of intraocular damage. A-mode and B-mode ultrasound examinations showed abnormal echoes in the vitreous (vitreous hemorrhage) and a possible retinal detachment, indicating severe damage to the globe. The prognosis was confirmed by the clinical course, as phthisis bulbi appeared in several months. (Example of ultrasonic examination not presented.)

**Case 6.** S. B. is a 6-month-old girl, who was born two months premature. When first seen, she had a large esotropia of 50 diopters. There was a membrane behind the lens and retinal detachment. The findings were limited to the right eye, which was felt to be smaller in size. Ultrasound examination showed the right eye to measure 20 mm compared with 25 mm on the left side. The findings were probably due to retrolental fibroplasia (Fig. 10).

### Discussion

Ultrasound evaluation of the eye can give useful information in many situations where it is not possible to observe the fundus details directly.

In a blind patient, such as case 1, it was possible to save the patient from surgery and unnecessary expenses which would not have yielded any practical results. With the posterior damage detected by ultrasound, surgery was contraindicated and was not performed.

Case 2 enabled us to localize correctly an intraocular foreign body which was not visualized with the ophthalmoscope so that uneventful surgery and removal of the foreign body could be performed. Comparative evaluation of radiologic and ultrasound technics and the value of ultrasonic examinations are described by Runyan and Penner.<sup>10</sup> Special stress of false results by radiologic methods (Sweet localization) is described in bilateral foreign bodies of the eyes due to superimposition of images. This superimposition is not a problem in ultrasonic technic.

Case 3 illustrates how a good prognosis can be given and surgery recommended with reassurance

of the patient. In cases 1 and 5, extensive, irreparable damage was seen, giving a poor prognosis and contraindicating surgery. This demonstrates the importance of the additional examination.

Case 4 was not clean-cut and a definite diagnosis was not made. However, the mass was solid by ultrasound evaluation and could be detected by this method as it measured over 2.5 mm, which is the smallest lesion that can be outlined by sonograms.<sup>11</sup> This additional information to the clinical picture was helpful in forming the decision to enucleate the affected eye.

Case 6 enabled confirmation of the status of the posterior portion of the eye and showed microphthalmia as well as retinal detachment. The healthy status of the other eye was reassuring.

### Summary

Ultrasound evaluation has allowed more accurate diagnosis in difficult cases and added information which could not have been obtained by other methods. It is a simple, rapid and painless procedure, which has allowed us to avoid unnecessary surgery, to perform difficult surgery with greater ease and accuracy, and to give the patients reassurance or a more precise prognosis at a much earlier time in the course of their disease than it would have been possible otherwise.

**Acknowledgment:** Andy Seib, R.T., assisted in some of the studies performed and was instrumental in preparing the reproductions published.

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## Discussion of E.N.T. Case of the Month

(continued from p. 673)

The cause of epistaxis in the majority of patients in this age group is rupture of the sphenopalatine artery which has been previously weakened by arteriosclerosis.

However, bleeding from an occult tumor of the nose and/or paranasal sinuses must be ruled out.

The immediate evaluation of patients after removal of nasal packing is difficult. On direct examination, the nasal mucosa will be friable and have a granular appearance secondary to the trauma of the packing. This makes it extremely difficult to differentiate a possible malignant tumor from simple irritated nasal mucosa.

In addition, radiographic examination during the acute stage will almost always show clouding of the paranasal sinuses on the involved side secondary to blood which fills the sinuses. The blood in the sinus may obscure early lesions. Of course, gross areas of bone destruction will be seen during the acute phase.

If one waits three weeks and then re-evaluates the patient, the nasal mucosa will have returned to a near-normal appearance, and any suspicious areas that remain may be biopsied. The sinuses also should be examined radiographically at this time, since any clouding secondary to the epistaxis will have resolved, and an early lesion may be visualized.

The patient in this report was found to have a squamous cell carcinoma of the antrum as the



FIG. 1. Radiographic evaluation revealed clouding of maxillary sinus and a lytic lesion of roof of sinus (arrows).



FIG. 2. Lesions within maxillary sinus may be biopsied through the Caldwell-Luc approach, which consists of removing a small portion of bone from anterior wall of maxillary sinus.

source of his epistaxis. In this instance, the diagnosis was made while the patient was in the hospital because of the radiographic evidence of bone destruction. Figure 1 reveals the bone destruction of the floor of the orbit. Biopsy of the adjacent nasal mucosa failed to show tumor, so a direct

biopsy of the lining of the sinuses was accomplished through a Caldwell-Luc approach (Fig. 2). The patient was treated with a full course of radiation therapy followed by total maxillectomy and orbital exenteration. He is alive five years after this therapy.

**BE SURE TO SEE PAGE 719** —. There you will find a list of companies advertising in this issue of *The Journal*. Keep the list handy and refer to it when the detail men come around. Thank those whose companies help support us with their advertising and remind the others they should be doing so! After all, this is the official publication of the Ohio State Medical Association, not just any old generic publication. —*The Editor*



# Pulmonary Outpatient Rehabilitation

## A Four-Year Follow-Up

RICHARD A. KRUMHOLZ, M.D.

ON NOVEMBER 16, 1968, the Pulmonary Outpatient Rehabilitation Unit of the Charles F. Kettering Medical Center was opened. This unit is an integral part of our overall pulmonary comprehensive care program.<sup>1,2</sup> This program includes: (1) Respiratory Therapy Department; (2) Pulmonary Function Laboratory; (3) Pulmonary Outpatient Rehabilitation Unit; (4) Pulmonary Intensive and Intermediate Care Units; and (5) School of Respiratory Therapy. The aim of the Pulmonary Outpatient Rehabilitation Unit (POP) is to educate and rehabilitate patients with chronic pulmonary disease (primarily chronic ob-

### *The Author*

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structive pulmonary disease). The POP is staffed with a registered nurse, licensed practical nurse, respiratory therapist, secretary, and medical director. Figures 1, 2, and 3 demonstrate the unit. The unit contains one mechanical treadmill, two exercycles, one set of stairs, one rowing machine, two exercise walkers, two tilt tables, and a cardiac and pulse rate monitor with high-low alarm. There

From the Charles F. Kettering Medical Center,  
3535 Southern Boulevard, Kettering, Ohio 45429.  
Submitted February 13, 1973.

TABLE 1. Scale of Prices at C. F. Kettering Memorial Hospital Pulmonary Outpatient Rehabilitation Unit

|   |          |          |          |
|---|----------|----------|----------|
| <b>Grade I</b>                          |          |          |          |
| 1 Series of 5 classes .....             | \$ 6.00  | \$ 6.00  | \$ 6.00  |
| 13 Visits .....                         | 78.00    | 78.00    | 78.00    |
| With IPPB treatments .....              | —        | 71.50    | 71.50    |
| With postural drainage .....            | —        | —        | 78.00    |
|   | 84.00    | 155.50   | 233.50   |
| Diagnostic tests and entrance fee ..... | 147.00   | 147.00   | 147.00   |
| Total .....                             | \$231.00 | \$302.50 | \$380.50 |
| <b>Grade II</b>                         |          |          |          |
| 1 Series of 5 classes .....             | \$ 6.00  | \$ 6.00  | \$ 6.00  |
| Blow bottles .....                      | 6.00     | 6.00     | 6.00     |
| 18 Visits .....                         | 108.00   | 108.00   | 108.00   |
| With IPPB treatments .....              | —        | 99.00    | 99.00    |
| With postural drainage .....            | —        | —        | 108.00   |
|   | 120.00   | 219.00   | 327.00   |
| Diagnostic tests and entrance fee ..... | 147.00   | 147.00   | 147.00   |
| Total .....                             | \$267.00 | \$366.00 | \$474.00 |
| <b>Grade III</b>                        |          |          |          |
| 1 Series of 5 classes .....             | \$ 6.00  | \$ 6.00  | \$ 6.00  |
| Blow bottles .....                      | 6.00     | 6.00     | 6.00     |
| 22 Visits .....                         | 132.00   | 132.00   | 132.00   |
| With IPPB treatments .....              | —        | 121.00   | 121.00   |
| With postural drainage .....            | —        | —        | 132.00   |
|   | 144.00   | 265.00   | 397.00   |
| Diagnostic tests and entrance fee ..... | 147.00   | 147.00   | 147.00   |
| Total .....                             | \$291.00 | \$412.00 | \$544.00 |

are 14 oxygen outlets placed in strategic areas around the unit.

All patients must be referred to the program by a physician. Referrals may be either as an inpatient or an outpatient. The inpatients are taken into the program only after their active disease process has been stabilized. The operation of the unit is completely on a private basis. No patient,

TABLE 2. Goals of C. F. Kettering Memorial Hospital Pulmonary Outpatient Rehabilitation Unit

- I. Develop rapport with each patient.
  - A. Provide maximum supportive care.
    1. Constant encouragement.
    2. Create relaxed and comfortable atmosphere.
    3. Activate appropriately toward decreasing depression.
  - B. Explain reasons for every therapeutic measure used.
- II. Educate patients with chronic obstructive lung disease to their maximum level of self-care.
  - A. Educate patients to their disease processes.
  - B. Aid patients in developing an understanding of mechanics of breathing.
    1. Classroom teaching (group discussions).
    2. Demonstrating to and working with patients all modalities of treatment.
    3. Individualized teaching.
  - C. Teach patients to live within confines of their disease to extent their abilities and individualities will allow.
  - D. Emphasize home exercises and practices.
- III. Educate families of patients to an understanding of the patients and their disease.
- IV. Maintain their level of activity.
  - A. Physical exercise.
  - B. Diaphragmatic breathing exercises.
  - C. Bronchial hygiene.
- V. Instruct other personnel (visiting, hospital, and student) regarding purpose and tools of pulmonary rehabilitation.

TABLE 3. Functional Grade Scale for Classifying Patients Into Pulmonary Outpatient Rehabilitation Program

|           |   |
|-----------|---|
| Grade I   | O <sub>2</sub> saturation above 92%, PO <sub>2</sub> above 65 mm Hg<br>PCO <sub>2</sub> normal, FEV 1.0 over 1.0 liter/sec<br>DL <sub>co</sub> — normal<br>Peak flow above 300 liters/min<br>Dyspnea grade II or III                              |
| Grade II  | O <sub>2</sub> saturation above 90%, PO <sub>2</sub> above 60 mm Hg<br>PCO <sub>2</sub> below 50 mm Hg<br>FEV 1.0 over 500 cc/sec<br>DL <sub>co</sub> 75% of predicted or greater<br>Peak flow above 150 liters/min<br>Dyspnea grade III or IV    |
| Grade III | O <sub>2</sub> saturation below 88%, PO <sub>2</sub> less than 55 mm Hg<br>PCO <sub>2</sub> above 50 mm Hg<br>FEV 1.0 below 500 cc/sec<br>DL <sub>co</sub> less than 75% predicted<br>Peak flow less than 150 liters/sec<br>Dyspnea grade IV or V |

TABLE 4. Dyspnea Grade Index Used to Classify Patients in Functional Grade Scale of Pulmonary Outpatient Rehabilitation Program

|           |   |
|-----------|---|
| Grade I   | Patient's breath is as good as that of other individuals of his own age and build at work, on walking, and on climbing hills or stairs. |
| Grade II  | Patient is able to walk with normal persons of his own age and build on the level but is unable to keep up on hills or stairs.          |
| Grade III | Patient is unable to keep up with normal persons on the level but is able to walk a mile or so at his own speed.                        |
| Grade IV  | Patient is unable to walk more than 100 yards on the level without a rest.  |
| Grade V   | Patient is breathless on walking or talking or is unable to leave his house because of breathlessness.                                  |

TABLE 5. Number of Pulmonary Outpatient Visits Based on Functional Grade Scale

|           |  |
|-----------|--|
| Grade I   | 1 hr. per day X 5 days — week 1<br>1 hr. per day X 3 days — week 2 and 3<br>1 hr. per day X 2 days — week 4<br>13 sessions   |
| Grade II  | 1 hr. per day X 5 days — week 1 and 2<br>1 hr. per day X 3 days — week 3 and 4<br>1 hr. per day X 1 day — week 5 and 6<br>18 sessions  |
| Grade III | 1 hr. per day X 5 days — week 1 and 2<br>1 hr. per day X 3 days — week 3 and 4<br>1 hr. per day X 2 days — week 5 and 6<br>1 hr. per day X 1 day — week 7 and 8<br>22 sessions |

however, has been refused admission into the program based on lack of funds. Table 1 discloses the charges as made by the POP. Table 2 defines the goals of the unit.

During the first clinic visit, the patient fills out a programmed history form and is interviewed by one of the workers regarding transportation, finances, and other matters. A physical examination by a member of the house staff is set up. (This is not done if the patient brings a recent physical examination report from his own physician.) A complete blood count, blood urea nitrogen, electrocardiogram, posteroanterior and lateral chest film, and complete pulmonary function studies including arterial blood gas analysis, pulmonary diffusing capacity (DL<sub>co</sub>), forced vital capacity (FVC), forced expired volume (FEV) at 1.0, 2.0, and 3.0 seconds, FEV 200 to 1200 ml., FEV 25 to 75 percent, peak flow (PF), maximal voluntary ventilation (MVV), airways resistance (RAW), total lung capacity (TLC), functional residual capacity (FRC), and residual volume (RV) are then done. All flow rates are done before and after bronchodilator. The patient

TABLE 6. Program Patient Statistics

| Year | Total Patients in Program | Died (Total) | In Grade III Program | In Grade II Program | In Grade I Program | Grade III Died | Grade II Died | Grade I Died | Disinterested | Coming | Ill | Treated Elsewhere | Will Call | Never Completed Program |
|------|---------------------------|--------------|----------------------|---------------------|--------------------|----------------|---------------|--------------|---------------|--------|-----|-------------------|-----------|-------------------------|
| 1968 | 7                         | 3            | 6                    | 0                   | 1                  | 3              | 0             | 0            | 2             | 0      | 1   | 0                 | 0         | 1                       |
| 1969 | 68                        | 6            | 51                   | 10                  | 7                  | 16             | 0             | 0            | 18            | 15     | 3   | 2                 | 1         | 9                       |
| 1970 | 92                        | 12           | 69                   | 17                  | 6                  | 9              | 2             | 0            | 23            | 23     | 7   | 0                 | 11        | 15                      |
| 1971 | 62                        | 3            | 46                   | 11                  | 5                  | 3              | 0             | 0            | 10            | 28     | 1   | 1                 | 4         | 12                      |
| 1972 | 41                        | 1            | 30                   | 9                   | 2                  | 1              | 0             | 0            | 0             | 36     | 2   | 0                 | 0         | 2                       |

TABLE 7. Mortality Rate of Patients with Severe Chronic Obstructive Pulmonary Disease

|                    | 1 Year | 2 Year | 3 Year | 4 Year |
|--------------------|--------|--------|--------|--------|
| Present Study*     | 6%     | 17%    | 31%    | 50%    |
| Boushy & Coates†   |        |        |        |        |
| ABG‡               | 27     | 41     | 51     | 59     |
| MVV‡               | 30     | 44     | 52     | 58     |
| FVC‡               | 30     | 44     | 53     | 61     |
| Renzetti, et. al.† |        |        |        |        |
| Group 1            | 36     | 59     | 78     | 90     |
| Group 2            | 8      | 22     | 37     | 44     |
| Burrows & Petty†   |        |        |        |        |
| Denver             | 12     | 24     |        |        |
| Chicago            | 15     | 30     |        |        |
| Burrows & Earle†   |        |        |        |        |
|                    | 7      | 21     | 34     | 41     |

\*Yearly mortality

†Cumulative mortality

‡Criteria used for classification

is then scheduled for a series of five educational classes on pulmonary anatomy, physiology, care of the respiratory tree, and approaches to self therapy, ie, breathing retraining, avoidance, postural drainage, etc. These classes last 40 to 60 minutes per session and are held five days a week. Each class on a given subject is held the same day of each week so that if a day is missed the patient may pick it up the next week. Also during this time (the week of classes), a clinical conference is held on each patient by all workers in the unit and the medical director and, based upon the clinical and physiologic status, he is slotted into a functional classification grade (Tables 3 and 4). To fit into each grade, the patient must meet three of the criteria in one of the functional grades listed in Table 3. This functional classification grade dictates the number of visits each patient makes to the clinic. Table 5 demonstrates the frequency of clinic visits based upon classification grade. The functional classification grade was arbitrarily set up prior to the opening of the unit and, to our experience, it has been very workable.

All rehabilitation in the unit is done one-on-one except during the classes. The activity during

each visit is individualized to the patient by the therapist and varies from breathing retraining and passive maneuvers through active treadmill exercise. Inhalation therapy and/or postural drainage precedes active rehabilitation only when ordered by the patient's private physician. All exercise is done with O<sub>2</sub> support if the resting PO<sub>2</sub> is 60 mm Hg or less. Patients with an abnormal resting electrocardiogram (ECG) are monitored during exercise. Any medical problems arising during the program are handled by consultation with the patient's private physician. Upon completion of the official program, return visits are scheduled at three, six, and nine months, and yearly thereafter. At each long-term return visit, a programmed form is filled out by the patient (Figure 4) and pulmonary function studies are repeated.

Table 6 demonstrates our program patient statistics. A number of important points are noted from this table. Our grade III patients are comparable in disease severity to those patients in the studies of Boushy and Coates,<sup>3</sup> Renzetti, et al,<sup>4</sup> and Burrows and Petty.<sup>5</sup> The patients in the study of Burrows and Earle<sup>6</sup> are consistent with our grade II and III patients. Table 7 shows the mortality percentages of the present study as compared to the studies mentioned above. The age range in all of the studies is similar.

### Mortality Figures

The mortality rate per year in the present study (grade III patients) is superior to all other reported studies of patients with this degree of pulmonary function abnormality and chronic obstructive pulmonary disease. Our mortality figures were derived by taking the patients entered into the program by December 31 of each year and calculating the percent having died from that date through November 1972. This adds a certain bias against us, as patients entering early in a given year actually may have as much as one extra year of time in the program. Therefore, since the prospective nature of the study precludes a true cumulative mortality table, we feel our method of calculating the mortality rate is comparable (or even harsher on our statistics) to the



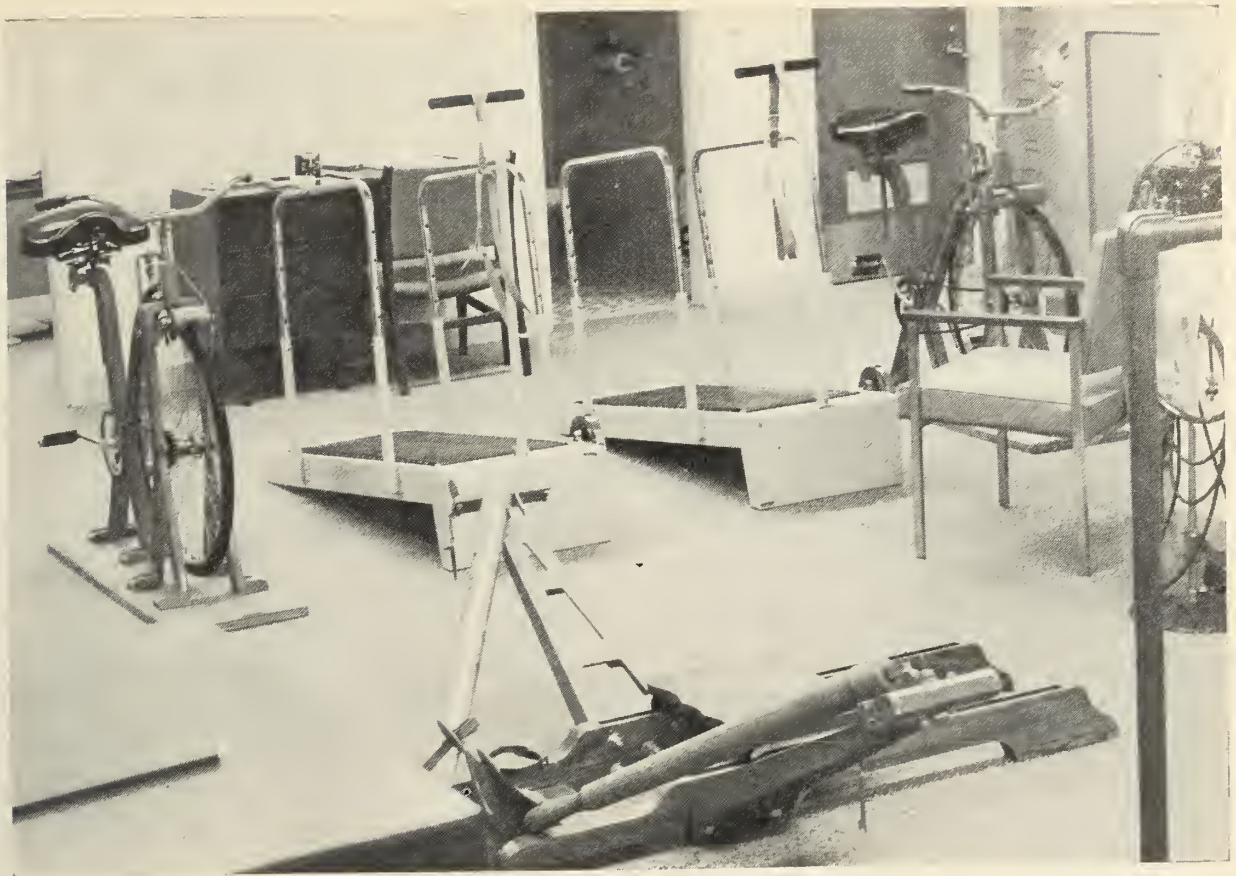


FIG. 1. Pulmonary outpatient rehabilitation unit.



FIG. 2. Patient using treadmill.



FIG. 3. Patient using exercycle.

| Name  | Date        |
|---|-------------|
| Physician   | Interviewer |
| 3-6-9-Month and Yearly Interview  |             |
| <ol style="list-style-type: none"> <li>1. Maintained breathing pattern?</li> <li>2. Do you have a specific inspiratory/expiratory ratio?</li> <li>3. Is sputum production increased?<br/>Do you wheeze?</li> <li>4. Have you been daily practicing your deep breathing exercises as well as your physical activity?<br/>How often?</li> <li>5. Are you still able to cope with shortness of breath as when you completed the program?</li> <li>6. What seems to be the best form of exercise for deep breathing?</li> <li>7. What form of physical activity is best for you?</li> <li>8. Is your activity greater than, less than, or the same as when you completed the rehabilitation program?</li> <li>9. Has the breathing regimen and exercise helped you at work and/or at home? Any way specific?</li> <li>10. Have you had any infections during this three-month period? If so, what did you do to care for yourself?</li> <li>11. Have you done postural drainage in the last three months? How often?</li> <li>12. Would you grade your condition the same now as when you entered the program?</li> <li>13. Do you have any periods of fatigue?</li> <li>14. Do you smoke now? How much?</li> <li>15. Are you still using your nebulizer or handevent? Are there any problems with its operation?</li> <li>16. How do you feel about a visit every three months?</li> <li>17. Do you have any comments, suggestions, or questions?</li> </ol> |             |

Fig. 4. Form completed by patient on return visits after completion of official program.

cumulative method. The closest published mortality figures to ours are those from the study of Burrows and Earle<sup>6</sup> and to be entered into their study, an FEV 1.0 of less than 60 percent was needed. This is a less stringent criteria than that used for our grade III patients (Table 3). It is important to note that the 122 physicians having referred the 270 patients into our program are, for the most part, general medical physicians. Therefore, any positive findings regarding patient mortality would seem to emanate from the benefit of the program and/or the care received from their private physicians. Since the care by the private physicians was in all probability standard, general medical care for patients with chronic obstructive pulmonary disease, it would seem that the combination of the

program plus standard private medical care is responsible for the lower mortality figures. The patients in this study were mostly private paying patients, and this factor was not present in most other published studies regarding mortality and chronic obstructive pulmonary disease. The effect that this factor had on the present mortality figures remains undetermined but must be mentioned nonetheless.

It was also noted that the mean age of those patients who died (67.6 years) was considerably above the mean age of those who survived (59.7 years). All ages were taken as of the time of entrance into the program and all deaths as of November 1972.

There are other encouraging aspects to the program. Even though grade III necessitates 22 visits, the completion rate was uniformly high, averaging 81 percent over the four years. Also, 52 percent of those completing the program and still living are returning for their follow-up evaluation.

The current study then has shown that a private hospital pulmonary rehabilitation program can be successful both from the aspect of patient involvement with their illness (quality of life) and improved mortality rates in patients with severe, chronic, obstructive pulmonary disease. It was also noted that those patients who died were considerably older than those still surviving.

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# Movement Disorders Secondary to Drugs

GEORGE W. PAULSON, M.D.

THERE ARE NUMEROUS movement disorders that can be related to drug ingestion, and they can be acute or apparently permanent. Movements may be produced by a direct toxic effect of the drug on the nervous system, by an indirect effect via changes in total body metabolism, and most commonly of all, through an "overflow" or "release" when the drugs are suddenly stopped after prolonged ingestion. This report cannot cover all drug-related movement disorders, but it is hoped that certain fundamental types of drug effects can be mentioned. There will be emphasis on several major problems that remain in drug and central nervous system interactions as demonstrated through movement disorders.

## Movements

*Tremor.* — The most common effect of drug ingestion, and particularly after drug withdrawal, is tremor. Although various types of drugs can intentionally produce tremor as an experimental project (eg, tremorine), many of these drugs really produce a shivering or myoclonic movement rather than a typical fine rhythmic tremor. One variety of tremor that most readers have personally experienced is the rapid (greater than eight cycles per second) type of tremor seen with excitement or fear. Tremor of an entirely similar pattern is seen after ingestion of large amounts of caffeine and after injection of adrenaline. This movement disorder affects all parts of the body, but it is particularly likely to involve the hands or facial muscles.

Tremor induced by adrenaline is increased with action, and it tends to subside with rest. Any of several sedatives serve to ameliorate this tremor, and lack of sleep or intense excitement definitely exaggerates it. It is probable that the fine tremor of hyperthyroidism represents a similar phenomenon. This type of rapid, at times "toxic," tremor

## The Author

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is perhaps the most fundamental though poorly understood of the movement disorders of the nervous system. The movement awaits systematic investigation with anticholinergic, antiserotonic, and antiadrenergic drugs. If we understood the biochemistry of this tremor, we also might understand drug and alcohol withdrawal and treat them more rationally.

*Myoclonus.* — Myoclonus is a rapid non-rhythmic jerk, symmetrical or nonsymmetrical, which often can be triggered by stimulation. In addition to tremor, myoclonus has been seen with several types of medication that can produce tremor, particularly when extremely toxic doses are employed. In animals, levodopa in very high doses can lead to a myoclonic movement, and severe electrolyte imbalance. Viral infections of the central nervous system, or uremia can produce myoclonus in humans. These and other toxic agents can lead to a combination of both tremor and myoclonus.

Mercury has come under scrutiny recently. In mercury poisoning, there may be not only peripheral neuritis, encephalopathy, and difficulties with the integument, but the fine tremor with metal poisoning may also be quite striking. Phosphorus and arsenic poisoning may also lead to tremor, in the latter instance perhaps partially due to loss of position sense, which produces a "pseudoathetoid" state when the patient fails to perceive the location of the fingers. The late effects



of carbon monoxide poisoning can also be associated with myoclonus or simple generalized tremor, as well as dystonic postures or parkinsonism.

*Parkinsonism.* — Many agents can produce a parkinsonian appearance, beginning first of all historically with reserpine. Methyldopa can also produce a parkinson-like state. Because of the opposite clinical features of Parkinson's and Huntington's disease, methyldopa has been suggested for use in Huntington's disease, but it is of dubious value. Manganese miners, people with exposure to carbon disulphide, and a few of those individuals severely damaged by carbon monoxide, may develop a parkinsonian-like picture. In manganese miners, the dystonic aspect is usually more prominent than the tremor, and the disease is atypical when compared to idiopathic parkinsonism. The tremor of pseudoparkinsonism seen with drugs, particularly pseudoparkinsonism secondary to phenothiazines, is probably faster than the tremor of idiopathic parkinsonism.

### Agents

*Heavy Metals.* — Intoxications with various heavy metals produce abnormalities of the nervous system. Some of these particularly affect the basal ganglia and thereby produce movement disorders. It is of some interest, from a comparative point of view, to note that deposits of calcium, iron, copper, and manganese all affect the basal ganglia in certain clinical situations. A good example of this, an example which does bring out one interesting point, is Wilson's disease. In this condition, either a dystonic state may be seen or the patient may have a bizarre and severe "flapping" tremor. Although many patients have combinations of both dystonia and tremor, it is of interest that it is primarily children who have the dystonic state, while adults are more likely to manifest the fine tremor. This is one of several examples of the fact that an apparently similar process produces a different clinical appearance when it occurs at different ages. The tremor of Wilson's disease is quite coarse and perhaps worse when the arms are extended than when the arms are at rest. Most people with action tremor are more incapacitated as their hands approach the object, but such is not necessarily the case with the tremor of Wilson's disease. It is uncertain what the pathophysiologic basis of this particular movement may be but it seems unlikely that copper alone produces the abnormal movement pattern.

*Phenothiazines.* — The best example of the complex interrelationship between drugs and movement disorders is, of course, the phenothiazines. There are at least three major movement disorders related to the phenothiazines that the

clinician should be aware of, over and beyond the slowing down, inertia, and obtundation that are seen with large sedative doses of phenothiazines.

1. The best known drug effect is "pseudoparkinsonism" which begins after some weeks, and which continues so long as the drug is given. This consists of a mask-like facies, shuffling gait, and a tremor which is demonstrated better by walking than at rest. Some patients also have rigidity about the neck and shoulders. Even the typical ulnar deviation of the hands seen in patients with severe parkinsonism can be noted, and all of these aspects of parkinsonism may disappear (and almost always do) when the drugs are reduced. Parkinsonism induced by drugs responds somewhat to antiparkinson medications, and for unexplained reasons, this drug-induced movement disorder is slightly more prominent in women than in men.

2. Approximately 15 years ago, a more severe and acute phenomenon was recorded with phenothiazines for the first time. Reminiscent somewhat of the oculogyric crises noted in post-encephalitic parkinsonism, it consists of severe dystonic neck spasms, waves of muscle rigidity, stiffness or protrusion of the tongue, and intermittent tightness about the neck and shoulders. Extreme anxiety or an elevated blood pressure may be associated with this phenomenon. The spasms are relieved by sleep and usually subside within a day after the medication is discontinued. In contrast to the pseudoparkinsonism which occurs several weeks after ingestion of the medicine, the dystonia may be an acute effect of small amounts of the drug. The acute dystonia is more likely to occur in children than young adults and is more common with particular phenothiazines such as prochlorperazine or trifluoperazine hydrochloride. This particular effect of phenothiazines is improved dramatically by diphenhydramine hydrochloride, benztropine mesylate, or even sleep induced by barbiturates.

3. The phenothiazines produce what has been called the tardive or complex dyskinesias. This movement is quite distinct from pseudoparkinsonism and from the acute dystonic state described. In tardive dyskinesia, there can be a permanent movement disorder involving the hands, mouth, and trunk. Buccolingual movements of the lips with licking, smacking, and chewing are often noted. "Piano playing" or in-and-out extension and flexion of the fingers is seen, and the toes may hyperextend to the extent that the top of the shoes are worn out. There is, in addition, a tendency to hyperextend the trunk. This movement pattern is best seen when the patient is not directly observed, since it can be suppressed by the patient. A large number of chronic patients in state hospitals have this disorder, particularly if brain damage or se-

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**Contraindications:** Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

**Warnings:** Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis. In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

**Precautions:** Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

**Adverse Reactions:** Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

**Dosage and Administration:** The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

**Pro-Banthine P.A.**—Each tablet of Pro-Banthine P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

**How Supplied:** Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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**Pro-Banthine**®  
brand of  
propantheline bromide  
a good option in peptic ulcer



## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

## Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

Insomnia may often accompany surgical convalescence. During those long nights following surgery, sleep can be as elusive as it is vital.

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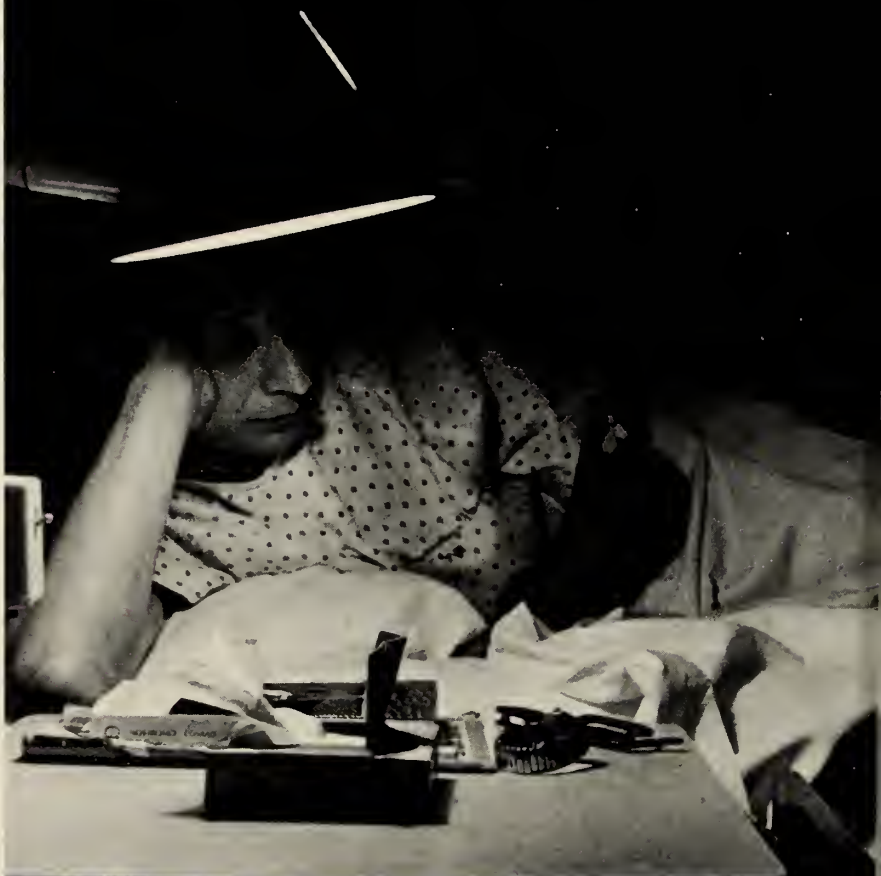
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Prescribed by physicians for over 17 years.

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(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)





nility are also present. This movement is also more common in females, and it can be irreversible.

**Dextroamphetamine.** — Dextroamphetamine is an example of how complex drug relationships can be. Large doses have been reported to produce a pattern identical to the tardive dyskinesias just discussed. Smaller doses lead to a fine tremor and a sense of restlessness. On the other hand, in certain clinical situations, such as when it is used in minimal brain dysfunction or in the hyperactive child, Dexedrine actually seems to suppress restlessness, incoordination, or impulsive, stumbling behavior. In this instance, in fact, Dexedrine serves as a quieting agent.

### Questions and Discussion

There are numerous major, unsolved questions with regard to how movements are produced or affected by drugs. Thought and motion are inseparably linked and additional information in these areas is of importance for studies of memory, judgment, and behavior. It is apparent that there are marked differences in individual responses to drugs, and the interrelationships between the characteristics of the individual and the drug is crucial. Many normal people can suppress the effects of almost all the psychotropic drugs for prolonged periods of time. In addition to individual differences in sensitivity, it is obvious that it is not solely the dose level that is significant but the length of time plus sudden changes in dosage that are crucial. For example, it is often only after withdrawal from medication that extreme tremulousness is observed. Furthermore, major toxic effects may be noted, if the medicine is increased rapidly, but toxicity can be minimal if increases are gradual. There is a selective vulnerability to particular drugs not only for certain individuals but in parts of the nervous system as well. One drug affects the cortex, another the reticular activating system, and a third has a hippocampal effect. For example, on rare occasions diphenylhydantoin sodium in large doses may destroy the Purkinje cells of the cerebellum, leading to a permanent ataxia by this means. Other drugs, as mentioned before, appear selectively to damage the basal ganglia.

The phenothiazine story indicates the complexities of drug administration and their effect on the nervous system. The tardive dyskinesia can be a permanent anatomic or structural change related to the prolonged biochemical insult. It is postulated that there may be a change in receptor sites produced by prolonged administration of the phenothiazines. It has been suggested that in Parkinson's disease and Huntington's disease, the

normal level of dopamine or of other neurohumors produces a different effect when the receptor site has been injured or irreversibly altered.

Furthermore, age of the patient has a fundamental effect on the level of response. It is the young that are likely to develop acute dystonia from phenothiazines. This may reflect not only the immature state of the neurologic substrate or local neurohumoral differences in the young but also overall imbalance in the rest of the body in immaturity.

The phenomenon of withdrawal is crucial in understanding drugs, and has not been intensively studied from a biochemical point of view. The withdrawal effects of many different kinds of medication are identical, and the tremor resulting from withdrawal from numerous drugs looks similar. Whatever metabolic derangement does occur when neurally active drugs are rapidly withdrawn, the change appears to be a universal phenomenon. It affects all animals, all ages. There is, in management of drug withdrawal, a general clinical reliance on sedatives. It can be postulated that more specific biochemical antidotes to drug withdrawal can be discovered. One obvious series of therapeutic trials would include adrenergic, anticholinergic, dopaminergic, or serotonergic blockers.

### Summary

Numerous drugs can produce a movement disorder as an unwanted side effect. In addition to drugs that produce hypokinesia or hyperkinesia, abnormal movements can result from toxins such as the heavy metals. The phenothiazines demonstrate the variety of effects since this group of drugs can produce, not only the well-known "pseudoparkinsonism," but in addition, an acute dystonic reaction. A third effect is the "tardive" or chronic dyskinesia seen after prolonged ingestion of phenothiazines. Tardive dyskinesia involves primarily hands and mouth, and may result for the first time when the medication is reduced in dosage. It has been suggested that this movement disorder results from distortion in the receptor sites of the central nervous system. As uncertain as the explanation for this movement disorder, the explanation for the effects of drug withdrawal are even less well known. Whatever the explanation for the tremulousness seen with withdrawal, development of a rational therapy for the phenomenon will represent a major therapeutic advance.

### Generic and Trade Name of Drug

Dextroamphetamine sulfate — Dexedrine (Smith Kline & French)



# Maternal Deaths Among Ohio Teenagers

## A 16-Year Study\*

ANTHONY RUPPERSBERG, JR., M.D.  
CHAIRMAN, OSMA COMMITTEE ON MATERNAL HEALTH

**D**URING THE PAST FIVE YEARS, there has been a progressing tendency to focus our attention upon the adolescent youth. This timely trend has involved our social, economical, spiritual, educational, and medical disciplines.

The fanatic frustrations of teenagers have been laid to social problems, more liberal attitudes, a lack of communications, drugs, and a "morality gap."

Many medical and social problems have developed since the emancipation and sexual "boom" of youth. Illegitimate pregnancies, estimated at 141,000 in 1950, rose to 339,000 in 1968; in the past decade, they are reported to have increased 300 percent. One half of the teenage brides are pregnant!<sup>1,2</sup> The maternal mortality rate for teenagers is reported to have shared an equal decline, in comparison to older females, in this country.<sup>1</sup> Nevertheless, since very little has appeared in the literature concerning teenage *maternal deaths*, we were prompted to survey the Ohio Study in the hope of accumulating data which would help to save lives in the future.

### Purpose of Survey

The purpose of this survey is threefold: (1) to explore various avenues in the background and etiology of teenage maternal deaths in Ohio; (2) to compare these data with those of other reports published previously; and (3) to stimulate interest and action toward the prevention of maternal deaths of teenagers in the future.

In our survey, we began by screening the total number of births over the 16-year period, 1955 to 1970. From statistics furnished in a letter dated Oct. 12, 1972 from Julius E. Wilson, Jr., Statistical Analyst, Ohio Department of Health, we found that teenagers contributed 12.9 percent of the total births, 14.6 percent of the live births, and 1.2 percent of the stillbirths. This compares favorably with figures reported for the United States.<sup>1</sup> During the

16-year period, the Committee found that there were 1094 maternal deaths; 94 (8.59 percent) of these were teenagers. These appeared among a total of 1,500 cases on file. Again, in screening, we found that 35 additional teenagers in question were voted *nonmaternal* deaths, eg, they had no connection with the state of pregnancy, while 94 teenagers were voted *maternal* deaths. Three of the 94 were under the age of 15 years. We found that 33 (about one-third) were nonwhite; and 61 (about two-thirds) were white. This does not compare favorably with previous reports of Ballard and Gold<sup>1</sup> and Menken.<sup>3</sup> Considering the marital status of the 92 teenagers reported, 53 were married, one of these was under the age of 15 years, one was divorced, and 38 were single, two of which were under the age of 15. One out of every 11 Ohio births is recorded as being illegitimate but, as has been pointed out in previous reports, illegitimacy is only a symptom, the underlying factors are emotional and physical.<sup>3</sup> Considering the past medical history of these patients, the predominant feature was *cardiac* disease. Forty-six (about one-half) of them had *no* positive history whatsoever; categorically, this group was healthy! We found variable statistics in the previous obstetric history; occasionally, some of the figures were multiples of others. However, 39 of the 94 were primagravidae and 55 were multigravidous patients. Sixty-six *had* had one or more term pregnancies, while five *had* had one or more premature babies. We reviewed the records of the mothers who had children living or dead. Twenty-two of our patients died undelivered, but 30 of them had one child born alive and now living, 15 had two children born and now living, and six had one born alive but now dead. There were 12 stillborn babies in this group. In summary, 45 infants *survived* among the 85 teenagers reported. The social consequences are obvious.<sup>1,2,6</sup>

### Prenatal Care

Prenatal care always receives the focus of attention in a discussion of maternal deaths. Of the 81 applicable cases, 40 (about one-half) had adequate prenatal care; 19 had inadequate care, and

\*Condensed from a paper presented at the 47th Anniversary Congress, Pan American Medical Association, Miami Beach, Florida, Nov. 11, 1972. (Twenty statistic tables omitted.)

22 had none at all. It might be added that several factors are responsible for the late or inadequate prenatal care among teenagers. They are reported to be due first to a frightened or frustrated adolescent girl who delays appearance for care, hoping she is not pregnant or hoping she will abort spontaneously.<sup>1</sup> Second, she usually registers late in a public or clinical service because of economic stress. And third, frequently she finds an attitude of cold indifference and disinterest in the physician and staff nurses. There not only is a lack of communication but a lack of in-depth counselling.<sup>3</sup> Previous reports indicate that late or little prenatal care leads to the development of toxemia, anemia, prematurity, infant mortality, and sometimes mental retardation.<sup>1,4</sup> There is the inevitable paradox: those who are *high risk* teenage pregnant patients receive less prenatal care!<sup>1,2</sup>

### Prematurity

In an effort to screen our patients for *stage* of gestation and derive some statistics concerning prematurity, we first took the *gestational age*; 50 of our 94 patients had term pregnancies. However, approximately 24 (25.5 percent) were either premature or immature in the birth of their babies. Screening against these figures, we investigated the weight of infants that were delivered. Forty of the group of 94 were unknown, or were ectopic pregnancies, or aborted. Only 20 (37 percent) of the remaining group of infants were premature by *weight*, or less than 2500 grams. Of the patients with complications of labor, 54 had none, four developed abruptio placentae, and 18 had anesthetic complications. Of the anesthetics administered, ten were regional and eight were general anesthetics. There were three ruptured uterus deaths but the predominant feature ranking next to anesthetics was toxemias; there were 14 of these.

### Route of Delivery

The *route* of delivery was next explored. We found that 53 of our 94 patients delivered by the vaginal route. Fifteen (16 percent) had antemortem cesarean sections. This higher rate compares with the previous reports.<sup>1,2</sup> There were no post-mortem cesarean operations. Four patients were submitted to laparotomies for ectopic pregnancy, one ectopic pregnancy patient was one of the 22 patients who died undelivered. Type of delivery: Eight were spontaneous deliveries, 37 were operative term (either forceps or breech extractions, or other complications), six were spontaneous prematures, eight were operative prematures. Next we screened the third stage of labor and its complications; 37 patients had normal third stages, ten developed hemorrhage, six had abnormal placentas of some type, and three patients with ruptured

uteri were in this group. The one predominant feature was uterine atony with seven cases, while one patient had an inverted uterus. Place delivered: 22 patients died undelivered but of the remaining group, 69 delivered in a hospital, while three delivered at home.

### Child Outcome

Frequently, this very interesting facet is overlooked in studies related to *maternal* deaths. Twenty-two had "no outcome" or the adolescent *died* undelivered; however, 48.8 percent of the 94 patients had *live* births. There were five ectopic pregnancies, abortion was associated with ten, there were 11 stillbirths, and three of the live-born had neonatal deaths. Of the complications of the puerperium, first in rank was hemorrhage; 14 patients had early hemorrhage and in addition to this, five also defibrinated. In comparison to anesthesia (with 18 deaths) these were next in order. Among patients who developed sepsis, the majority had septicemia of which five were due to criminal abortion. Urinary tract infections were present in five, and upper respiratory infection was seen in six patients. Among "other" complications of the puerperium, six had some cardiac problem; 13 patients died of embolism of which five were *air* embolism (Table). It is interesting to report that one of these patients was a 16-year old, married primigravida, approximately six months pregnant, who attempted to take a vaginal douche because of leukorrhea. Upon closing the vulva she suddenly experienced pain, cried out, and her mother found her dead on the bathroom floor. The coroner discovered air embolism! Ten patients had toxemia as a complication of the *puerperium*.

Next, we examined records pertaining to the interval between delivery and death. Twenty-five of our 94 patients died six hours or less after delivery. Fifteen died from six to 24 hours after delivery; 32 died 24 hours to 28 days after delivery, and 22 died undelivered. It might be added that among the 94 maternal deaths, 81.5 percent were subjected to autopsy. This figure compares favorably with the Michigan Study, where 79 percent were studied at autopsy,<sup>5</sup> and with our Ohio 10-Year Survey with 72.6 percent of the 779 maternal deaths subjected to autopsy.<sup>7</sup>

### Cause of Death

Of course, we were curious to learn the *primary* cause of adolescent deaths. Fifteen patients died of *hemorrhage*, eight died of *infection* while 16 died of *toxemia*, and 55 died of "other causes" (Table). Examining the *major* contributing causes of the 15 dying of hemorrhage, five had ectopic pregnancies, four died of uterine atony, and three had ruptured uteri.

Among the eight that died of infection, five died in connection with criminal abortion. And



Leading Causes of 94 Teenage Maternal Deaths in Ohio, 1955-1970

|                                   |    |
|-----------------------------------|----|
| Hemorrhage                        | 15 |
| Toxemia                           | 16 |
| Anesthesia                        | 18 |
| Embolism (thromboembolic and air) | 12 |
| Remainder                         | 33 |

of the 16 that died of toxemia, 12 were due to eclampsia. In the 55 "other causes," foremost was *anesthesia*, with 18 deaths; as mentioned, eight were *general* anesthetics, while ten were regional anesthetics. Embolism (thromboembolic, air) accounted for 12 maternal deaths of which five were air embolism. Eight patients died of cardiac disease, while five developed *amniotic-fluid*, pulmonary embolism. One patient died of "trauma, massive, automobile," after developing eclampsia, en route to the hospital. She was the driver! Toxemias and sepsis have been reported as lead causes of death in other studies.<sup>1,2</sup>

### Preventability

The Committee always determines the preventability of maternal deaths. In this series of 94 maternal deaths, the Committee voted 27 (28.7 percent) *nonpreventable*. However, 67 (71.2 percent) of the 94 cases were considered *preventable* maternal deaths. Of these, patient responsibility was present in 20, while personnel responsibility was present in 37, and both factors were present in ten patients. Under avoidable factors, 27 of the 94 maternal deaths were voted *nonpreventable*, and constituted an unavoidable catastrophe. However, 24 of the preventable group had had *inadequate* prenatal care, but approximately 34.3 percent of the group were due to errors in both judgment and technique on the part of the personnel. (We consider personnel to include anyone who has to do with the care of the patient, including the physician, interns, residents, externs, nurses, and others.)

### Summary

1. A survey of 94 teenage maternal deaths is presented from the Ohio Maternal Mortality Study.

2. These occurred among 1094 maternal deaths during the years 1955 through 1970, and teenagers accounted for 14.6 percent of the 3,411,783 live births reported in Ohio during the 16-year period.

3. Over 30 statistical facets associated with the 94 patients are carefully analyzed and reported. Brief references compare selected statistics with those of other reports.<sup>1,7</sup>

4. Anesthesia, toxemia, and hemorrhage (in order) are assigned as a *primary* cause of death to the majority of the 94 patients.

5. The Committee on Maternal Health voted 71.2 percent of the 94 maternal deaths as *preventable*; members assessed 34.3 percent of the *avoidable factors* to personnel *judgment and technique*, and 35.9 percent to inadequate prenatal care.

### Conclusions

1. Family life education, and instruction in contraceptive usage must be programmed more carefully.<sup>1,2</sup>

2. An *expert* course of prenatal care must be made available and should be sought *early* by the "high-risk" teenage, obstetric patient.<sup>2</sup>

3. Homes for unwed teenage mothers have been recommended, especially for those in the lower socioeconomic brackets.<sup>2,3</sup> These homes (established in four metropolitan Ohio areas) not only shelter the unmarried girl, but they also educate her in diet and hygiene, and encourage her to continue prenatal care and attendance at school. However, from an economic standpoint these facilities are becoming progressively *less* practical each year.

4. Better lines of communication must be established between the adolescent and her family, her school, the physician, the nurse, and other agencies which deliver health care.<sup>1,2,6</sup>

5. We realize that, although there were only 94 teenage maternal deaths in Ohio during this 16-year period, *many* other pregnant teenagers barely escaped inclusion in the study, by developing *ONLY* morbidity of various nonfatal degrees. The teenage pregnant parturient *must* be classified as a "high-risk" obstetric patient!

"Every pregnant adolescent girl should be considered 'an accident, looking for a place to happen' . . . until proven otherwise."<sup>1</sup>

**Acknowledgment:** The continued efforts of The Committee on Maternal Health, OSMA members, and numerous other individuals and agencies, in maintaining the Ohio Maternal Mortality Study are gratefully acknowledged.

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# Professional Activities



## Proceedings of The Council

Meeting of July 14-15, 1973

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, July 14-15, 1973, at the OSMA Headquarters' office, 17 S. High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council; Dr. John H. Budd, Cleveland, a member of the AMA Board of Trustees; Dr. John W. Cashman, Columbus, Director of the Ohio Department of Health; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Mr. Mark L. DeBard, Columbus, Student AMA Representative; Messrs. Page, Edgar, Gillen, Clinger, Rader, Mrs. Wisse, Mr. Moore and Mrs. Dodson, of the OSMA staff.

Those present Sunday were: All members of the Council; Dr. Richard L. Meiling, Columbus, Chairman, Ohio Delegation to the AMA; Dr. Budd, Mr. Pohlman, Mr. DeBard; Messrs. Page, Edgar, Gillen, Clinger, Rader, Mrs. Wisse, and Mr. Moore.

### In Memory

The Council stood for a moment of silence in memory of the late David Fishman, M.D., Fifth District Councilor, and the following resolution was adopted, with a copy to be sent to his family:

#### MEMORIAL TO DAVID FISHMAN, M.D.

David Fishman, M.D. was widely known and respected for his medical leadership and his ability as a practicing physician.

To every task he undertook David brought

his keen mind and a balanced sense of how best to get a job done.

David was a kind, soft spoken, friendly man with a warm smile, whose first love was his family.

He was a humanitarian with a deep sense of responsibility to his community and to all aspects of Medicine. For these reasons he was involved in many efforts to help his fellow men. We will not here attempt to name the many societies, boards, and committees with which David was associated. His tremendous drive and commitment bring to mind these lines from a Robert Frost poem:

*But I have promises to keep,  
And miles to go before I sleep,  
And miles to go before I sleep.*

David's gift of time, talents, and enthusiasm have made Cleveland and Ohio a better place for many people.

Now therefore be it resolved, by the Council of the Ohio State Medical Association, that we record this remembrance in our minutes and forward a copy to the members of his family as an expression of our appreciation.

### Minutes Approved

Minutes of the meetings of March 17-18 and May 10 were approved.

### Council Vacancy

The Council considered the matter of appointing a Councilor for the Fifth District, an

office left vacant by the death of Dr. David Fishman. The Council received letters from Drs. James R. O'Malley, P. John Robeck, Kenneth W. Clement, Lawrence J. McCormack, David A. Chambers, and Joseph L. Gaglione.

The Sixth District Councilor, Dr. Lieber, announced that, at the request of President Clarke, he had contacted the presidents of the counties comprising the Fifth District (Ashtabula, Cuyahoga, Geauga and Lake) and that all four counties indicated their support of John J. Gaughan, M.D., for appointment to fill the vacancy.

By official action Dr. Gaughan was appointed by the Council as Fifth District Councilor to serve until the next meeting of the House of Delegates in May 1974. (See page 705)

### AMA Alternate Delegate

The American Medical Association Alternate Delegate position left vacant by the death of Dr. Fishman was discussed and it was the decision of the Council that this position would be filled by the House of Delegates in May, 1974.

### Ohio Director of Health

John W. Cashman, M.D., Ohio Director of Health, then addressed the Council. The following matters were discussed by Dr. Cashman and the Council:

1. Medical Care in Ohio's Prisons and Jails.
2. Emergency Medical Care Services.
3. Implementation of the in-stage renal disease program by the Ohio Department of Health under provisions of the Social Security Act.
4. Federal support programs.
5. Legislative action involving plans for two additional medical schools.
6. Budgetary status of the Ohio Department of Health.
7. Operational aspects of the Governor's Cabinet Health Committee and its role in adjusting the capacity-demand aspects of health spending.

8. Plans for districting the state for administrative and for planning programs.

9. Ohio Board of Regents.

### Councilor District Reports

The Councilors reported on activities in their respective districts.

The Eighth District Councilor, Dr. Richard E. Hartle, was authorized to proceed with arrangements for possible combination of several county medical societies in the Eighth District, as provided

under Article II, Section 2, of the Constitution of the Ohio State Medical Association.

A file on the "Dayton Health Insurance Experiment" was presented for the information of the Council.

### Auditing and Appropriations

The Council approved the minutes of a meeting of the Auditing and Appropriations Committee, held July 14, 1973, as presented by Mrs. Wisse. The report established membership dues for the "Members in Training" category at \$10 per year.

The Council received information from the committee with regard to increases in the printing cost of *The Ohio State Medical Journal*. This report was accepted for information and referred to the Committee on Membership and Planning for study.

The adoption of the report also carried with it approval of a listing in the program of the American Society of Medical Assistants Annual Meeting and the approval of the purchase of new dictation and typewriter equipment.

### Finance and Membership

Mrs. Wisse indicated that as of July 1, paid memberships in the Ohio State Medical Association were running well ahead of last year.

### OSMA Annual Meetings

A report on the 1973 Annual Meeting and plans for the 1974 Annual Meeting were presented by Mrs. Dodson. The Council selected Saturday, May 10 through Wednesday, May 14 as the dates for the 1975 Annual Meeting in Columbus.

### New Section Established

By official action, the Council established a Section on Emergency Medicine of the Ohio State Medical Association and selected Dr. William L. Hall, of Columbus, Ohio, as the first chairman.

### Follow-Up on Resolutions

The Council thereupon took up those resolutions from the 1973 House of Delegates which were passed and which require implementation. The number of each resolution, a brief summary, and the Council action are as follows:

**Resolution No. 1-73, Members in Training.** This category is included in the new Bylaws. Dues were set at \$10 per year by Council.

**Resolution No. 3-73, Ethics of Charging Interest Rates.** Referred to Committee on Judicial and Professional Relations.

**Substitute Resolution No. 4-73, Departments**

of Family Medicine. Implemented by OSMA Legislative Staff.

**Substitute Resolution No. 6-73**, Ohio Department of Public Welfare Provider Agreement. Became AMA Resolution No. 128 (A-73). AMA Board of Trustees to study.

**Resolution No. 8-73**, Compulsory Formal Postgraduate Education. Received for information and referred to the Commission on Medical Education.

**Resolution No. 10-73**, To Authorize Contraceptive and Pregnancy Advice and Treatment for Minors without Parental Consent. Council instructed staff to proceed with preparation of legislation for 1974 introduction.

**Resolution No. 11-73**, Emergency Medical Care. Referred to OSMA Committee on Emergency and Disaster Medical Care.

**Substitute Resolution No. 13-73**, Abortion as a Medical Procedure. Received as basic policy and referred to the Committee on Maternal Health.

**Resolution 17-73**, The Ohio Medical Indemnity. Referred to Dr. Schultz, Chairman of the OMI Liaison Committee, for transmittal.

**Substitute Resolution 18-73**, Discrimination Against Physicians by Phase III. Became AMA Resolution No. 94 (A-73). Copies sent to all state societies. AMA House directed that the objectives of the resolution be pursued.

**Resolution No. 20-73**, Medicine and Religion Academic Curriculum. Transmitted to Committee on Medicine and Religion.

**Resolution No. 23-73**, Private Practice. Council received reaffirmation of basic policy.

**Amended Resolution No. 25**, Preservation of the Confidentiality of Medical Records. Referred to Committee on Hospital Relations for study and preparation of legislation.

**Resolution No. 27-73**, Welfare. Council noted the approval by the House of its continuing activities to improve the Medicaid program.

**Substitute Resolution No. 29-73**, MAI-PSRO. Referred to Medical Advances Institute.

**Resolution No. 30-73**, Ethical Status of Provider Agreement. Referred to Committee on Judicial and Professional Relations.

**Substitute Resolution No. 33-73**, Deceased Medicare Beneficiaries' Bill. Council directed that the President communicate with the Social Security Administration and with the chairman of the Board of Trustees of the American Medical Association, with carbon copies of the communication to other state medical societies.

**Resolution No. 36-73**, Revenue Sharing and Health and Medical Services. The staff was in-

structed to notify the county medical societies of this action and request their implementation.

**Resolution No. 38-73**, Insurance Companies Inimical to the Private Practice of Medicine. Referred to the Committee on Insurance for study and implementation. Other states to be notified of the resolution.

**Resolution No. 41-73**, Smoking Areas in some Ohio Schools. Referred to the Committee on School Health.

**Resolution No. 43-73**, Malpractice "Nuisance" Suits. Referred to the Committee on Insurance for preparation of legislation to be sponsored in the Ohio Legislature in 1974.

**Resolution 49-73**, Maternity Hospital Regulations. Referred to the Committee on Maternal Health.

**Resolution 56-73**, Life Active Member. This has been included in 1973 Bylaws publication. Letter soliciting life active members issued July 17.

**Resolution 57-73**, Recruitment of Medical Students. Referred to First and Second District Councilors for implementation and report back in 90 days.

**Resolution 60-73**, Report of the Committee on Medical Education. Referred to the Commission on Medical Education for development of methods for implementation.

### American Medical Association

Minutes of the May 8, 1973, meeting of the AMA Delegation were presented by Mr. Gillen and received for information.

Dr. Meiling reported on the June AMA Annual Convention in New York City.

Dr. Meiling also discussed the activities of the AMA Long Range Planning Committee.

### Bylaws

Amendments to the Bylaws of the Academy of Medicine of Cleveland were approved.

### Charter

Reissuance of the Charter for the Lake County Medical Society was approved.

### MAI-PSRO

The following were presented for the information of the Council:

Minutes of the PSRO Council and Specialty Panels, April 7-8

MAI Board of Trustees minutes, June 13

Minutes of the PSRO Council, June 14

MAI Carrier Coordinating Committee minutes, June 7



## Ohio Medical Indemnity, Inc.

Dr. Schultz, Chairman of the OMI Liaison Committee, reported on recent meetings of the Executive Committee and the Board of Directors of Ohio Medical Indemnity, Inc. The report was received for information by the Council.

### Federal Legislation

Mr. Edgar reported the following developments: National Health Insurance hearings scheduled for next year; Presidential instructions to the Department of Health, Education, and Welfare, to write an Administration bill, and efforts of the Ohio State Medical Association to obtain a Congressional hearing on network programming.

### State Legislation

The Council made the following recommendations concerning current Ohio legislation:

**S.B. 132 and H.B. 343**, to remove architectural barriers in public buildings. Action: **Support.**

**S.B. 133 and S.B. 160**, to develop hemophilia programs in health departments. Action: **Referred to Committee on Laboratory Medicine.**

**S.B. 164**, to change podiatry laws. Action: **Watch for present time; needs further study.**

**S.B. 178**, to repeal Alcoholism Board. Action: **None. For information.**

**S.B. 206**, State aid for T.B. patients. Action: **Support.**

**S.B. 209**, to include test for gonorrhea along with syphilis in prenatal test. Action: **Referred to Committee on Laboratory Medicine.**

**S.B. 212**, to establish separate Chiropractic Board. Action: **Actively oppose.**

**S.B. 282**, cancer surveillance by Department of Health. Action: **Support.**

**S.B. 307**, dangerous drug bill. Action: **Oppose.**

**S.B. 336**, institutionalization of mentally ill. Action: **Needs further study.**

**S.B. 377**, licenses ambulances. Action: **Referred to the Committee on Emergency and Disaster Medical Care.**

**S.B. 378**, requires M.D. examinations prior to contact lens fitting. Action: **Referred to Eye Care Committee.**

**S.B. 379**, registers opticians. Action: **Referred to Committee on Eye Care.**

**H.B. 82**, weight lifting to require medical evidence. Action: **Actively oppose.**

**H.B. 467**, interim payments for Medicaid providers. Action: **Actively support.**

**H.B. 474**, family practice departments and residency programs. Action: **Support.**

**H.B. 528 and H.B. 790 and H.B. 856**, to li-

cense Physician's Assistants. Action: **Oppose under OSMA/OHA moratorium.**

**H.B. 573**, continuing education for optometrists. Action: **None—for information only.**

**H.B. 846**, protects physicians against claims of fraud in prognosis. Action: **Actively support.**

**H.B. 973**, to require chiropractors to be graduates of HEW accredited schools. Action: **Support.**

**H.B. 984**, commitment of mentally ill. Action: **Support.**

**H.B. 989**, abortion regulations. Action: **Actively oppose.**

### Health Manpower

The matter of health manpower was discussed and the Council instructed the President to confer with the Chairman of the Committee on Nursing with regard to changing the designation from Committee on Nursing to the Committee on Health Manpower.

### Committee Reports

#### Ohio Coalition for Quality Health Care Committee

Minutes of the meetings of the Ohio Coalition for Quality Health Care Committee of March 19, April 18 and July 9 were presented by Mr. Rader and accepted for information.

#### Ad Hoc Committee on Health Care Delivery Systems

Minutes of the Ad Hoc Committee on Health Care Delivery Systems of March 28 and July 11 were presented by Mr. Gillen. Minutes of the meeting of March 28 were accepted for information. Minutes of the meeting of July 11 were accepted for action. This report called for the establishment of a Board of Trustees of the Ohio Foundation for Medical Care.

#### OSMA/Ohio State Bar Association Committee

Minutes of the meeting of the OSMA/OSBA Committee of April 11, were presented by Dr. Clarke and were accepted for information.

#### Committee on Maternal Health

Minutes of the meeting of the Committee on Maternal Health, April 29, were presented by Mr. Gillen, and were accepted for information.

#### Committee on Mental Health

Minutes of the meetings of the Committee on Mental Health of May 20 and July 8 were presented by Mr. Clinger. The approval of the May 20 minutes included the approval to endorse an upcoming study of the delivery of mental health services in Ohio to be conducted by the Department of Mental Hygiene and Mental Retardation and the selection of Dr. Fernando J. Manalac,

*(Continued on page 702)*

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# "Prescription drugs – who should determine the maker?"

## Dispenser of Medicine

Clifton J. Latiolais  
President  
American  
Pharmaceutical  
Association



## Maker of Medicine

C. Joseph Stetler  
President  
Pharmaceutical  
Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to the patients...

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 20



should be an obligation of medical practice...

"Medical societies ought to conduct continuing campaigns to point out the substantial savings that could be realized thru deductible insurance and protection for catastrophic illness. At the very least, they should, in the patients' interest, question the tactics of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's nonsense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference with the private practice of medicine. And the public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

or 30 drugs that he selects to treat the majority of conditions encountered in his practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with the particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply notifying the patient that he is making the substitution. I would judge that few courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005



Steubenville, to represent the OSMA Committee on Mental Health on a special subcommittee to assist with the study and further that Dr. Carl G. Madsen, Painesville, join in this effort with Dr. Manalac and Dr. Gordon F. Ogram, who represents the Ohio Department of Mental Hygiene and Mental Retardation.

Also approved by Council was the committee's proposal for joint sponsorship of a conference on alcoholism and drug abuse for November 19, 1973, in Columbus.

Approval of the July 8 minutes included the support of H.B. 984, with certain amendments approved by the committee and the establishment of a rotating advisory committee to assist in consideration in cases involving physicians who find their professional status threatened by mental health problems including alcoholism and drug dependence. The Council requested the committee to select three of its members for this advisory committee and that county medical societies be notified of this service.

The Council also endorsed the committee's expressed opposition to H.B. 420, an omnibus drug bill and S.B. 307, which would require triplicate prescription systems. The Council agreed with the committee that S.B. 336 relative to the institutionalization of mentally retarded persons needs further study.

#### **Committee on Emergency and Disaster Medical Care**

Minutes of the meeting of the Committee on Emergency and Disaster Medical Care of May 26 were presented by Mr. Rader. The minutes were accepted for information, including the discussion of categorization of emergency rooms and the recommendation that a Section on Emergency Medicine be established.

The Council approved the concept of a Conference on Emergency Medical Services to be held in the spring of 1974.

#### **Joint Advisory Committee on Sports Medicine**

Minutes of the meeting of the Joint Advisory Committee on Sports Medicine of May 8, were presented by Mr. Clinger and were accepted for information.

#### **Subcommittee on Family Practice Scholarship**

Minutes of the meeting of the Subcommittee on Family Practice Scholarship of June 13, were presented by Mr. Clinger, and were accepted for information. The scholarship winners for 1973 were: Christopher L. Demas, Reynoldsburg, and Donald J. Kennedy, Athens.

#### **Council Fee Review Committee**

Dr. Bates reported on the meeting of the Council Fee Review Committee of July 13, 1973, as follows:

**Case No. 1**—Bureau of Workmen's Compensation, on appeal from the Academy of Medicine of Cleveland decision. The Committee recommended and Council concurred that the fee is considered reasonable.

**Case No. 2**—Bureau of Workmen's Compensation, on appeal from Guernsey County Medical Society decision. The Committee recommended and the Council concurred that the Bureau of Workmen's Compensation negotiate with the physician with regard to charges arising out of telephone consultations.

**Case No. 3** — Metropolitan Life Insurance Company, from Mahoning County. Council concurred with the committee that the reasonable fee would be \$150, with the contingency that the chairman contact the physician to determine if special circumstances were involved and if a meeting with the physician is indicated.

**Case No. 4** — Metropolitan Life Insurance Company, from Mahoning County. Council concluded that the case should be held over because of the need for more information.

**Case No. 5**—Aetna Life and Casualty Company, from Stark County. The Committee recommended and the Council concurred that a reasonable payment would be \$480, contingent upon the chairman contacting the physician concerning any special circumstances and a meeting with the physician if necessary.

**Case No. 6**—Banker's Life of Stark County. The Committee recommended and the Council concurred that a reasonable payment would be \$770, contingent upon the chairman contacting the physician with regard to any special circumstances and a meeting with the physician, if necessary.

**Case No. 7**—Aetna Life and Casualty Company.

7-A—Allen County decision sustained.

7-B—Allen County decision sustained.

7-C—Allen County decision sustained.

7-D—Allen County decision sustained.

#### **Grievance Cases**

A report from the District Councilors on the follow-up on grievance cases in their areas was presented to the Council. It was agreed that a letter be written by Dr. Clarke to the county medical societies, asking for their cooperation with the members of the Council in this procedure.

#### **Comprehensive Health Planning**

Dr. Clarke was instructed to communicate with Dr. John W. Cashman, Ohio Director of Health, with regard to a replacement for the late



Dr. David Fishman on the Ohio Comprehensive Health Planning Advisory Council.

### Pronouncing Death

With regard to a letter from the Ohio Nurses Association on the problem of pronouncing the death of a patient, it was requested that Mr. Edgar forward to the Nurses Association copies of his correspondence with the Attorney General of Ohio on this subject.

### SSA Kidney Program

With regard to the kidney program administered by the Social Security Administration, Mr. Edgar was instructed to contact the American Medical Association for additional material and then to prepare a communication to the Director of Health, Education and Welfare, with regard to this being a medical procedure rather than a hospital procedure.

### OSMA Transplant Committee

The Council instructed the President to appoint an organ transplant committee within the Ohio State Medical Association to work in conjunction with Medical Advances Institute and the Living Bank Committee, which is headed by Mr. Donald W. Moffat, WOSU Radio Ombudsman, Columbus, Ohio.

### Reporting Committee Activity

In answer to a suggestion from Dr. Karl W. Hess, of Cleveland, calling for more information with regard to the work of OSMA committees, the Council referred the matter to the Committee on Public Relations for development.

### Allergy Section

With regard to correspondence dealing with the Section on Allergy, the Council instructed the Public Relations Department to prepare an article pointing out the differences between a specialty society and a scientific section of the Ohio State Medical Association.

### Podiatry Relations

Dr. Wells reported on the June 27 meeting with Dr. Jerauld D. Ferritto, D.P.M., with regard to relations with the Ohio Podiatry Association. The President appointed an Ad Hoc Committee on Podiatry Relations: Dr. Wells, chairman; Dr. Meiling, Dr. Henry, and Dr. Paul Matrkka, of Columbus. Mr. Rader was designated to staff the committee.

### Cancer Deaths in the Ohio Valley

The Council received from Dr. Eugene L. Saenger, of Cincinnati, copy of a letter dated May 31, 1973, from Dr. Saenger to Governor Gilligan,

★

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along with copy of a paper "A Survey of Cancer Death Rates in the Ohio Valley," authored by Dr. Saenger. These communications were in reply to statements of Dr. Ernest Sternglass, of Pittsburgh, made on April 19, 1973, that there is an increase in total cancer mortality in Cincinnati as a result of water-borne radioactivity from the nuclear power reactor at Shippingsport, Pennsylvania. The Council voted its thanks to Dr. Saenger for his study and asked that the Committee on Environmental and Public Health take the matter under consideration.

### **Greene County Hospital Situation**

In answer to a request from the Administrator of the Greene County Memorial Hospital, the Council advised the Administrator to refer the inquiry to Dr. Robert R. Clark, President of Medical Advances Institute, for quality review. The Council also requested that the Administrator be advised that MAI-PSRO possesses the quality review mechanism if the hospital wishes to use it and that the request be with the cooperation of the appropriate medical staff and hospital board.

### **Cardiopulmonary Resuscitation**

A suggestion for a planned course in cardiopulmonary resuscitation for Administrative Assistants for Congressmen and Senators was studied by the Council. The Council voted to reply to the suggestion advising that first the Congressional physician should be consulted for his reaction and if it is positive an estimate should be prepared with regard to costs, including books, time, personnel and travel. The Council likewise expressed the opinion that OSMA should again look into the problem of first aid at the Ohio General Assembly.

### **Hospital Appointment Form**

The Council studied a hospital appointment form, which has been implemented at the Fisher-Titus Memorial Hospital, Norwalk, Ohio. The OSMA staff was directed to obtain the source of this form and the officers were instructed to convene the officers of the Ohio Hospital Association, the Ohio State Medical Association and the Ohio Osteopathic Association of Physicians and Surgeons, with regard to a discussion concerning the objectionable features of this material.

### **Ohio Health Providers Council**

The Council reaffirmed its approval of the concept of an Ohio Health Providers Council, with the top elective officer and an executive from each Association serving thereon, and instructed the staff to proceed with the organization.

### **Sidney Hillman Centre**

The Council received the request from Sol J. Benensohn, M.D., Medical Director of the Sidney Hillman Health Centre of Chicago, for a conference with the President of the Association. The Executive Director was authorized to set up an appointment.

### **State Journal Conference**

The Executive Director reported that in accordance with the instructions of the Council, he arranged for a conference of selected state medical journal representatives, officials of the State Medical Journal Advertising Bureau, and members of the staff of the American Medical Association with Mr. C. Joseph Stetler, President of the American Pharmaceutical Manufacturers Association, on June 26, 1973, in New York City. Mr. Page expressed the opinion that the conference was productive and that additional meetings will follow.

### **Travel Department**

Mr. Page reported that INTRAV, the Ohio State Medical Association's tour advisor, has agreed to make the Ohio State Medical Association a co-insured under the liability policies maintained by INTRAV.

### **Governor's Task Force**

Dr. Schultz reported on meetings of the Governor's Task Force on Health Care. Dr. Schultz requested specific and positive statements and concepts with regard to the areas covered by the Task Force. The President referred the matter to the Committee on Long Range Planning, requesting this committee to provide Dr. Schultz with this material.

### **Highland County Matter**

Four communications from Highland County with regard to problems arising among physicians were received by the Council and were transmitted to the First and Second Councilors for study and investigation.

### **National Health Service Corps**

A request from the Medina County Medical Society, asking for a change in wording of their resolution requesting a general practitioner through the National Health Service Corps Program was presented to the Council. This Society asked to change its request from one general practitioner to two. The Council concurred.

The meeting was then adjourned.

ATTEST: Hart F. Page  
*Executive Director*

# Cleveland Physician Appointed as Fifth District Councilor

The Council of the Ohio State Medical Association at its meeting of July 14-15 appointed Dr. John J. Gaughan, of Cleveland, as Councilor of the Fifth District to succeed Dr. David Fishman who died on May 22. The appointment covers the period up to the next meeting of the House of Delegates in May 1974.

Dr. Gaughan is a practicing physician in Cleveland, specializing in radiology, is a diplomate of the American Board of Radiology and is associated with a number of radiological organizations.



**John J. Gaughan, M.D.**

He comes to the Councilor office with a rich background of experience in professional organization work and in community activities. He was president of the Academy of Medicine of Cleveland, 1971-1972, a member of its Board of Directors from 1963 to the present, and has served as delegate from the Academy to the OSMA House of Delegates from 1963 to the current year. In the House of Delegates he has served on Reference Committees. He is a member of the American Medical Association, the Ohio Medical Political Action Committee, and the American Medical Political Action Committee.

Dr. Gaughan was born in Leetonia, Columbiana County, and received his early education there. He earned his B.S. degree from Adelbert College of Case Western Reserve University, and his medical degree from St. Louis University School of Medicine in 1946, after which he took his internship at St. John's Hospital, Cleveland, and residency training in radiology at the Crile VA Hospital, also in Cleveland.

During World War II he was in military service and immediately after the war was stationed in Japan as an Army medical officer.

Within the Cleveland Academy, he has served as chairman of at least eight key committees dealing with ethics, honors, mediation, membership, nominating, properties, and public relations, and the Academy's liaison committee with Medical Mutual. In other functions within the Academy framework, he has served on the Criminal Justice Coordinating Council, Health Insurance Appeals and Review Committees, Hospital Chiefs of Staff Committee, PSRO-Radiology Committee, the Special Committee on the Academy Foundation, Hospital Liaison Committee, Health Insurance Council Committee, and the Medical Advisory Committee to Blue Cross. He also worked with the Academy's Sabin and Rubella Vaccination Programs.

In his specialty field, Dr. Gaughan, in addition to being certified by the American Board of Radiology, is a Fellow of the American College of Radiology, a member of the Radiological Society of North America, the Eastern Radiological Society, the Ohio State Radiological Society, and the Cleveland Radiological Society. In the latter organization, he is currently president and has served as a member of its Council.

Another office he holds on the state level is that as councilor for the Professional Standards Review Organization of Ohio. He is also chairman of the Professional Standards Review Foundation of Northeast Ohio, and a member of the Medical Advisory Committee to Blue Cross of Northeast Ohio.

At St. John's Hospital in Cleveland he is president of the Medical Staff and director of the Department of Radiology. Also he is on the Advisory Board to the hospital and a member of its Board of Trustees.

Dr. Gaughan also is a member of the Cleveland Health Museum, the Cleveland Medical Library Association, and has served as area physician chairman for the United Appeal Drive, and area chairman for the Cancer Drive.

Dr. Gaughan is a member of the Catholic Church and a member of the Knights of Columbus. He and his wife Alma have five daughters, Marcia, a law student at Notre Dame; Sharon, a graduate student at William and Mary; Patricia, a junior at St. Mary's College of Notre Dame; Kathleen, a freshman at Indiana University; and Maureen, an eighth grader in Cleveland.



# Outstanding Exhibits Recognized at 1973 OSMA Annual Meeting

**F**EATURES OF THE 1973 OSMA Annual Meeting in Columbus included a very excellent display on the Exhibit Floor of the Veterans Memorial Building including Scientific, Health Education, and Technical Exhibits.

A judging committee selected several exhibits as outstanding and the sponsors were presented certificates of recognition as well as permanent type plaques to be displayed in respective booths and kept as permanent mementos.

A summary of exhibits selected as outstanding appeared in the July issue of *The Journal*, on page 556. Following is additional information on some of these exhibits. Information on more of the outstanding exhibits will be included in subsequent issues of *The Journal*.

## Gold Award Goes to Knee Replacement Exhibit

The Gold Award in the Teaching Field went to the exhibit entitled "Total Knee Replacement," sponsored by Thomas H. Mallory, M.D., of Columbus.

Following is a brief description of the material presented in the exhibit. Dr. Mallory has written a scientific article on this same subject which will appear in a coming issue of *The Journal*.

There is a spectrum of knee disease in rheumatoid and osteoarthritic patient that merits surgical management. The concepts of this surgical management are well presented in *The Orthopaedic Clinics of North America*, Vol. 2, March, 1971.

In the early stages of knee disease, when there is no evidence of loss of boney architecture, but persistent and uncontrolled synovitis, then synovectomy is indicated. When the boney architecture of the knee becomes mildly involved with deformity and disability, then corrective tibial osteotomy is the procedure of choice.

The above mentioned procedures have been the backbone of surgical management of knee disease; however, intrapositional arthroplasty has recently come to the forefront. Those knees which show marked destruction of boney architecture, demonstrate loss of ligamentous stability, and have persistent and uncontrolled pain are best salvaged by total knee replacement.

Basically there are two types of total knees; one constitutes an intrapositional design and the second a hinged joint design. The basic intrapositional total knees are the Polycentric and Geomedic, consisting of cobalt-chromium alloy materials cemented to the femoral condyles, articulating with high density polyethylene plastic on a tibial plateau. These prostheses require a certain amount of stability in the knee for predictable result.

When contractures, either valgus, varus, or flexion, equal more than 30° and/or pain and deformity are of severe nature, then the hinged type knee is the prosthesis of choice. This particular type of total knee design is inherently stable. Any degree of knee deformity can be corrected with the hinge joint.

The ultimate durability of total joint replacement remains in question. There are problems of loosening, wear, and infection. Nonetheless, there is every indication that these artificial joints will last five to ten years. For the severely afflicted arthritic patient with end-stage knee disease the benefits of total knee replacement are quite gratifying.

## Exhibit on L-Dopa Role in Cancer Pain Relief Awarded

The Gold Award in Original Investigation went to the exhibit entitled "Breast Cancer Bone Pain Relief with L-Dopa," sponsored by John Peter Minton, M.D., Department of Surgery, Ohio State University College of Medicine.

This exhibit also was awarded the Cancer Award, the citation and monetary gift from the Ohio Chapter, American Cancer Society.

Following is a brief summary of the material presented in the exhibit.

The important role of serum prolactin in breast cancer patients is just now being uncovered by radioimmunological assay of serum prolactin level in the human being. The discovery that L-Dopa suppresses prolactin levels, and simultaneously is associated in many patients with a sudden suppression of cancer cell growth rate is significant.

Many doctors have noted a dramatic response





The exhibit, "The Evolution of Total Knee Replacement," sponsored by Dr. Thomas H. Mal-lory, won the Gold Award in Teaching at the 1973 OSMA Annual Meeting. Shown proudly displaying the plaque is Carl Newman, Jr., who helped man the booth.



Dr. John P. Minton, center, sponsor of the exhibit entitled "Breast Cancer Bone Pain Relief with L-Dopa" is congratulated by Dr. William R. Schultz, 1972-1973 OSMA President, left, and Dr. Jack E. Tetirick, Scientific Work Committee chairman for winning the Gold Award in Original In-vestigation.

to hypophysectomy, adrenalectomy, and oophorectomy with bone pain relief from breast cancer metastasis. The reason for this response was not clearly understood.

Investigators in this field now believe that a greater than 50 percent decrease in serum prolactin levels literally turns off breast cancer membrane enzymes which permit cancer growth in one out of three breast cancer patients.

The sponsor proposes that the L-Dopa test is an important method of evaluating the effectiveness of the surgical endocrine ablative treatment of breast cancer. In addition, investigators have found that phenothiazine may adversely effect breast cancer patients, and should not be used since they increase prolactin levels.

## Exhibit on Dizzy Patient Receives Silver Award

The Silver Award in the field of Original Investigation went to the exhibit entitled, "The Dizzy Patient (Current Surgical Management), sponsored by Edward L. Hendershot, M.D., and James W. Wood, M.D., of the Department of Otolaryngology, Lutheran Medical Center, Cleveland.

Following is a resume of the exhibit and the background of material presented as prepared by one of the sponsors.

Until recently, the diagnosis and treatment of vertigo was poor, to say the least. The treatment consisted of prescribing a medication and hoping that the patient improved before the prescription ran out. Unfortunately, this predicament persists.

The purpose of this exhibit was to acquaint the general medical profession with both the newer methods of diagnosis and classification of vertigo and also two surgical procedures to cure the vertiginous patient while conserving or improving his hearing. These operations are the endolymphatic subarachnoid shunt (1) for Meniere's syndrome, and the middle fossa vestibular nerve section (2) for disorders of the vestibular nerve.

Although criticism exists, it is melting under the sheer weight of the surgical successes. The best known success is that of astronaut Alan Shepard, who had debilitating Meniere's syndrome. After his successful endolymphatic subarachnoid shunt, he was able to go to the moon.

### References

1. House WF: Subarachnoid shunt for drainage of endolymphatic hydrops. *Laryngoscope* 72:713-729, 1972.
2. House WF: Surgical exposure of the internal auditory canal and its contents through the middle cranial fossa. *Laryngoscope* 71:1363-1385, 1961.

## Exhibit on Acoustic Tumors Wins Silver Award

The Silver Award in the Teaching Field went to Sabino T. Baluyot, M.D., and John M. Tew, Jr., M.D., of Cincinnati, for their exhibit entitled "Diagnosis and Treatment of Acoustic Tumors."

The background of material presented in the exhibit was described in a brochure as follows.

Modern otology and radiology provide the methods for accurate diagnosis of acoustic nerve tumors. Advances in surgical techniques permits total tumor removal with preservation of normal neurologic function if the tumors are recognized during the early stage of growth (stage I). Yet, discovery of the lesion when small and easily removable depends on the suspicion and acumen of the primary clinician.

The acoustic neuroma originates as a result of a neoplasia of Schwann cells on the eighth cranial nerve within the internal auditory canal (IAM). It is a benign tumor whose presence may be recognized by symptoms related to eighth nerve compression and expansion of the tumor into the cerebello-pontine angle.

Small tumors (stage I) or intra-canalicular neuromas are confined to the internal auditory canal. Signs and symptoms include deafness, tinnitus, and dizziness. Hearing loss is classically unilateral and progressive. Diagnosis may be facilitated by examination of the eighth nerve by the tuning fork (auditory) and caloric tests (vestibular).

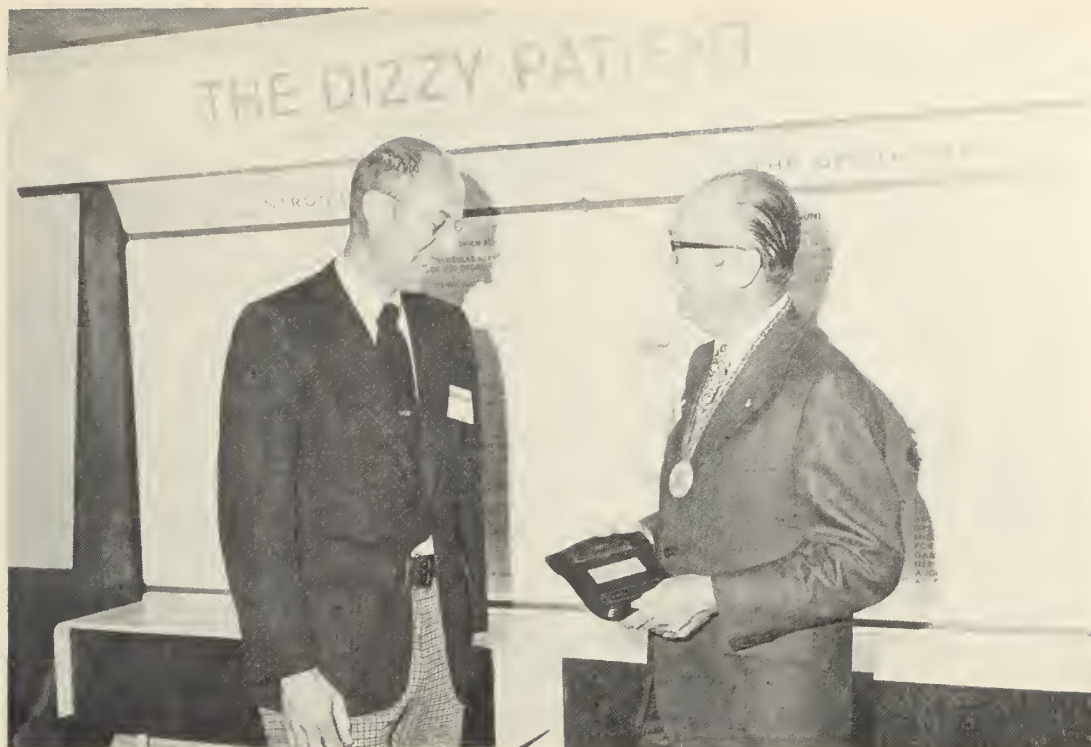
Medium size or stage II tumors, up to 2.5 cm., may compress neighboring cranial nerves. Facial weakness (VII nerve) may be a complaint. Numbness and paresthesias indicate trigeminal (V nerve) involvement; a diminished corneal reflex is the earliest sign of fifth nerve compression.

Late or stage III tumors, larger than 2.5 cm., may compress the lower cranial nerves (IX, X, XI) resulting in dysphagia and dysphonia. Symptoms of headache, blurred vision and ataxia usually indicate increased intracranial pressure. Involvement of the brain stem and cerebellum result in ataxia and hydrocephalus. Death may be impending.

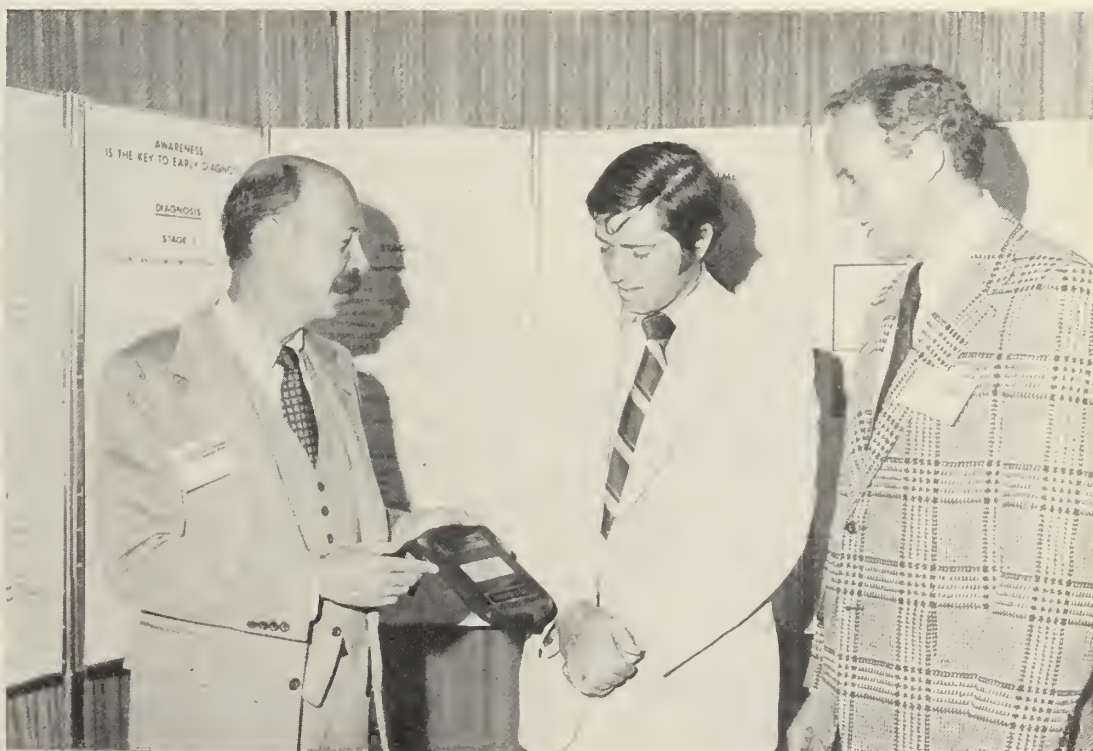
When an acoustic tumor is suspected the patient should undergo neuro-otologic and radiographic examinations designed to establish the definite cause of the symptoms. Treatment is surgical and a pleasing recovery can be expected in patients with early stage tumors. Although total removal can be achieved in stage III tumors, it is frequently at the expense of significant loss of neurologic function such as facial palsy, facial numbness and increased ataxia.

(Text Continued on page 710)





One of the sponsors of the exhibit on "The Dizzy Patient," Dr. Edward L. Hendershot, left, is about to receive the Silver Award in Original Investigation from Dr. William R. Schultz, 1972-1973 OSMA President.



Dr. Jack E. Tetirick, chairman of the OSMA Committee on Scientific Work, is shown presenting the Silver Award in Teaching to sponsors of the exhibit "Diagnosis and Treatment of Acoustic Tumors." Center is Dr. Richard Wiet and on the right is Dr. John M. Tew, Jr.



## Immunofluorescent Studies in Autoimmune Diseases

The Bronze Award in the Teaching Field was presented for the exhibit entitled, "Immunofluorescent Studies in Autoimmune Diseases," sponsored by Sharad D. Deodhar, M.D., Ph.D., of the Department of Immunopathology, Cleveland Clinic Foundation.

Following is an abstract of material presented in the exhibit, as furnished by the sponsor.

During the past seven years, various immunofluorescent procedures were introduced in the Immunopathology Department for the study of autoimmune diseases. Our experience in this area has been summarized to illustrate

(a) The basic principles in the pathogenesis of autoimmune disease,

(b) The laboratory procedures for demonstrating various auto-antibodies,

(c) The clinical incidence of these auto-antibodies in their respective autoimmune diseases and

(d) The usefulness of these procedures in the clinical diagnosis and management of patients with autoimmune disease.

The exhibit thus serves as a clinical immunopathologic correlation for this group of diseases. The exhibit consisted of four panels arranged in the following manner. The first panel was devoted to (1) Currently accepted definition of autoim-

mune disease, (2) A list of possible mechanisms leading to induction of autoimmunity (activation of forbidden clones leading to development of cellular and humoral auto-antibodies) and finally, autoimmune disease, (3) General characteristics of autoimmune disease, and (4) A list of some of the more commonly accepted autoimmune diseases with the appropriate autoantibody and the auto-antigen.

Panels 2, 3 and 4 were devoted to immunofluorescent and histopathologic illustrations of various autoimmune diseases with the illustration of appropriate autoantibody such as, antinuclear factor in SLE, parietal cell antibody in pernicious anemia, thyroglobulin antibody in autoimmune thyroiditis, skeletal muscle antibody in myasthenia gravis, mitochondrial antibody in primary biliary cirrhosis, smooth muscle antibody in lupoid or chronic active hepatitis, antiglomerular basement membrane antibody in Goodpasture's syndrome, antibody depositing in the intercellular regions of the epidermis in pemphigus vulgaris, antibody depositing in the basement membrane in bullous pemphigoid, antibody in the cytoplasm of the cortical cells in primary adrenal atrophy (Addison's disease).

The sponsor has coauthored a number of articles on the subject presented and similar subjects. Reprints may be had by writing the sponsor at the Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland 44106.



This exhibit, entitled "Immunofluorescent Studies in Autoimmune Diseases" won the Bronze Award in the Teaching Field at the OSMA 1973 Annual Meeting.

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**INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

**PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

**CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

**WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

**ADVERSE REACTIONS:** Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

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# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

I DON'T SUPPOSE I can pretend that the large yellow-haired dog received a Doctor of Medicine degree from the University of Cincinnati School of Medicine at its graduation exercises early in June, but believe me when I tell you that the dog almost stole the show that hot Sunday afternoon! I was there to see a very special young friend of mine, Ralph Beasley, receive his MD degree and neither I nor anybody else in that crowded auditorium could stem the laughter that followed the sudden appearance of the animal. Almost arrogantly he crossed the platform and took his position and would not budge.

This isn't exactly Auxiliary news, I realize, but it's really too choice an item to let go by. In your mind's eye, picture the platform and the distinguished faculty in cap and gown seated thereon. At the lectern stands the keynote speaker, Dr. Charles (Carl) A. Hoffman, 1972-73 President of the American Medical Association, and he is addressing the graduates. And, of course, it is a serious and momentous occasion. And that's when the yellow-haired canine chose to appear and almost disrupted the dignified proceedings!

Just once he sauntered off the platform, only to return almost immediately. One member of the faculty tried to keep the dog by him but wasn't too successful. The animal was not wearing a collar, so that it was almost impossible to hold on to him . . . Even the hooding of the graduates failed to faze him, but he was thoughtful enough at that point not to get in the way. He was quiet enough and I don't recall hearing even the tiniest of barks.

And although he remained onstage throughout the proceedings, the initial commotion he created subsided fairly quickly and the dignity of the occasion remained. What's that oldie about every dog wanting to get into the act?

## Mrs. Pfahl and Legislation

In drawing up her plans and schedule for this Auxiliary year, Mrs. S. B. Pfahl, state legislation chairman, has emphasized that "we in the Auxiliary need to 'Be Prepared' to include politics and legislation as our major goal for 1973-74." She goes on to point out that politics and legislation rule and guide our lives and the lives of our families . . . they are the ways by which we are able to collectively live together in a complex and often bewildering world, with a sense of order and direction . . . doctors' wives can no longer stand by and not know what is happening in Washington, D.C., and our state capital.

Here is what Mrs. Pfahl emphasizes as necessary preparation: LISTENING — to what is being said; READING — to become more knowledgeable; GROWING AND MOVING — to assist the medical profession and our country to be a better place to live.

"We have many jobs that need to be done, a job for everyone" says this most competent and energetic legislation chairman. Working through the Auxiliary's LEGS program (legislation effort group system) she lists these channels of activity: LEGS to write letters; LEGS to make phone calls;

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LEGS to make visits; LEGS to listen to the radio and watch television; LEGS to assist voters; LEGS to read; LEGS that will communicate; LEGS that will support medicine in its struggle to preserve the freedom of choice for both doctor and patient, and quality health care within the reach of everyone; LEGS that will help promote doctor-patient relationship so there is still identity of a very personal nature available to each person; LEGS that will help permit quality health care without bureaucratic involvement. Fifi Pfahl makes this plea: "Be a Good Scout and Be Prepared" — for medicine's sake.

### Here and There

Mrs. William Noble, Allen County community service chairman, was a member of a live panel a few months ago on a follow-up program of the nationally re-run television special "VD Blues." "Hotline" calls were received at the station (Bowling Green's new Public Broadcast Station) from the public seeking venereal disease information. Prior to the re-run, Mrs. Noble and members of her committee spent considerable time giving programs on VD in the local schools. In recent years, the venereal disease project has been one of the Allen County auxiliary's major activities.

Clark County doesn't believe in losing any time "pushing" a major social event and money-maker. It's all for the group's Nurse Scholarship Fund. Each member received a special newsletter in July, no less, calling attention to the "Bachelor's Honeymoon" to be presented on September 26 and 27 at Springfield's Dinner Theater. There will be cocktails at 6 p.m., a buffet dinner at 7:00 p.m. and the rib-tickling comedy presentation at 8:30 p.m. The tickets sell for \$9 each and reservations are necessary. Clark County members Linda Brown and Anne Titus are in charge of the ticket reservations.

### Erie County

During May ceremonies at the home of Mrs. Charles Everett, Mrs. S. Baird Pfahl was installed as president of the Erie County auxiliary. Also installed were Mrs. Everett as president-elect, Mrs. W. D. Parker as vice-president, Mrs. Richard Williamson as secretary, and Mrs. Frank Leake as treasurer.

Outgoing president, Mrs. Dean Reichenbach, presented decoupage plaques to Mrs. George Pasterak and Mrs. Tom Schoepfle for their outstanding contributions to the auxiliary during the past two years. The plaques were designed by auxiliary member Mrs. William Seiler. A contribution was made to AMA-ERF in honor of Mrs. Pasterak and Mrs. Schoepfle. Also recognized for outstanding efforts to the community in the field of health

care through other groups or organizations were Mrs. C. F. Lavender, Mrs. Arthur Groscoast, Mrs. Everett and Mrs. Henry W. Lehrer. It seems to this reporter that this kind of member recognition for outstanding activity should be copied by every other auxiliary in Ohio!

The Erie County group had a very good program recently on nutrition. Mrs. Watson Parker reviewed the assistance programs available in the community, in which she outlined the administration of these programs and those who are eligible to receive assistance in them. Mrs. Lowell Hoffman presented a thought-provoking report on food additives and the impact advertising has on our acceptance of them. Mrs. Paul Vasquez arranged for a representative of a health food company to display his products, answer questions and play a tape on the value of health foods. Mrs. Edward Gillette, chairman of the panel, presented the theory of dieting as promulgated in the book *The Diet Revolution* by Dr. Atkins, following which she reviewed the AMA's stand against it.

### Twenty-First Century

The April meeting of the Hamilton County auxiliary featured a knowledgeable, interesting and important speaker, Henry J. Heimlich, M.D., who took his listening audience into medicine in the

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**(See Page 716)**

21st century. Dr. Heimlich is director of surgery at the Jewish Hospital in Cincinnati, physician-in-chief of the Esophagus Center at the hospital and associated clinical professor of surgery at the University of Cincinnati College of Medicine. He is the inventor of the Heimlich chest drainage valve. Here are some of the doctor's fascinating comments and predictions:

"In very few years, by design, there will be many more women physicians and surgeons. Perhaps 50 percent. Therefore, your auxiliary membership will be 50 percent husbands. I would like, therefore, Ms. Chairperson, to be considered the first to address the Persons' Auxiliary . . .

"Predictions can only be made on the basis of what is known. What totally new discoveries or inventions will develop beyond that is unpredictable . . . The following medical predictions can be stated as being absolutely within the realm of possibility based on facts now available:

**"Predicted Medical Changes — In Teaching** — teaching machines; instillation of education into the brain electronically; separation of the scientist and teacher. **In Therapeutics** — chemicals to eliminate arteriosclerosis; vaccines or chemicals to cure or eradicate cancer. **In Biological Science** — alteration of genes to eliminate congenital and mental diseases as well as other pathological conditions; ability to hit one chromosome with laser; manufacture blood substitutes. **In Surgery** — my personal involvement in working with replacement

of the esophagus makes this easy to predict; transplantation of organs so necessary now, to be replaced by manufactured organs; the advantages — can implant artificial blood vessels, atom-powered pace-makers, totally replace hip joint; have artificial hearts, lungs, kidneys, outside the body; will be miniaturized for implantation. Same for artificial sight. The purpose will be to make a better life by manufactured organ replacement (spare parts) to replace single organs that age.

"The most important responsibility of medicine in the future is the preservation of life on this planet. The potential of destroying all life on earth necessitates changes in our thinking. The survival of the human race is now an international matter.

"In the 21st century, specialized treatment will be carried out in a limited number of centers. Rapid diagnostic consultation from computerized centers is already available and will expand. I do not know whether this concept is pleasing to today's physicians, but it is coming rapidly. Before the scientific era, it was enough to learn about the past and live by custom and rituals, planning only for the immediate future. Change occurs so rapidly now that it is necessary to plan for the distant future. Physicians have a particular responsibility in such planning, since science and compassion are unified in the work of the doctor . . ."

*(Continued on Page 716)*

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In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

**Possibly Effective:**

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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734017

1. Gertler, M. M., et al.: *Geriatrics* 25:134-148 (May) 1970.

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## Elsewhere in the State

The Lucas County gals are always busy-busy-busy. Each month I receive the *Bulletin of the Academy of Medicine of Toledo and Lucas County* in which there is a good-sized section reserved for Auxiliary activities and events. And each month I can hardly believe my eyes when I see the calendar of "dates to remember."

Here is that of May, just by way of example: the 3rd — Mobile Meals Tea honoring volunteers; the 4th — Senior Citizens Tea (the program featured Dr. Philip Horowitz who discussed the problems of the heart patient); the 14th — Citizens Day Care Luncheon for volunteers; the 16th — "Let's Get Together Time," the annual luncheon meeting at the Inverness Country Club; the 23rd — 1973-74 organizational board meeting.

In April, the Health Careers Committee had a very successful workshop for high school counsellors. Over 50 such counsellors from the area attended. Dr. Howard Madigan planned and moderated the outstanding program which was followed by a gourmet luncheon. Also in April the Aesculapian Ball V was held and netted \$1,150.00 for Mobile Meals. And also in April was the Project Hope fund-raising in which the auxiliary lends active cooperation. This time it was a Decorator's Show House that included a champagne reception. It was the auxiliary, as part of its International Health program, which was the motivating agent to start support for Project Hope in Toledo.

## Scioto-way

The home of Dr. and Mrs. Jerome Rini was the scene of the annual May breakfast of the Scioto County auxiliary. This traditional breakfast always features the installation of new officers. Mrs. Samuel L. Meltzer, installing officer, used as her theme the golden anniversary of the National Auxiliary. There was the pledge of loyalty and the presentation to each new officer of a "helping hand" figure on a bamboo holder.

Those installed included: Mrs. Ralph W. Lewis, president; Mrs. Rini, president-elect; Mrs. George V. Johnson, vice-president; Mrs. B. U. Howland, treasurer; Mrs. Manuel M. Pezeshki, secretary; Mrs. John A. Walker, historian; and Mrs. Daniel A. Martelino, member of the board.

The retiring president, Mrs. David E. Livingston, was presented with a gift. A memorial service for the late Mrs. Richard L. Wagner was conducted by Mrs. Charles W. Wendelken who also offered the invocation.

## The "George Award"

Mrs. Joseph Hamilton, Tuscarawas County president, was the recipient recently of the Tuscarawas County Chamber of Commerce "George Award" — the first time it has been presented to a woman. Nicknamed the "Georgette Award" in Mrs. Hamilton's honor, it is considered one of the community's outstanding honors. It takes its name from the popular saying "let George do it," and is awarded annually.

Mrs. Hamilton was chosen for her innumerable gifts of service to her county, the most recent of which is the organizing of the newly instituted "Mobile Meals" program of providing low-cost, nutritious meals for elderly shut-ins. In addition to her auxiliary presidency, this dedicated doctor's wife is president of the Mobile Meals program. She is also involved with the Red Cross and its many projects, the Salvation Army, First United Methodist Church, the United Way and the Tuscarawas County Philharmonic. Which makes all of us, over the state, very proud of our distinguished colleague. Congratulations . . .

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**(See Page 713)**

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**INDICATIONS:** *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

*Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

**CONTRAINDICATIONS:** Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

**PRECAUTION:** As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

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## Cleveland Physician Named President-Elect of Art Group

Dr. Victor C. Laughlin, of Cleveland, was named president-elect of the American Physicians Art Association at the New York meeting of the organization in connection with the 36th Annual Art Exhibition at the AMA Convention.

A number of Ohio physicians presented entries in the Art Exhibition, among them Dr. Andrew S. Burton, Newark; Dr. Leon Goldman, Cincinnati; Dr. Donald W. Kim, Cleveland; Dr. Victor C. Laughlin, Cleveland; Dr. Samuel W. Robinson, Columbus; Dr. Henry D. Rocco, Newark; Dr. Robert D. Waltz, Euclid; and Dr. Walter B. Wozniak, North Ridgeville.

The American Physicians Art Association is a nonprofit organization the purposes of which are to further the art interest of the medical profession and to stimulate physician artists to produce works of art in the fields of painting, sculpture, photography, graphic arts, design and creative crafts. The APAA sponsors exhibitions at AMA conventions.

Physicians interested in more information are invited to contact Dr. Laughlin at 3270 Green Road, Cleveland 44122.

## Medical Information Service on Cancer Is Announced

Through the American Cancer Society, Ohio Division, Inc. a medical information service on cancer is now available to the physicians, dentists and nurses in Ohio.

The American Cancer Society is providing six to seven minute prerecorded medical lecture-consultations via toll-free long distance telephone. The messages on this system are from M.D. Anderson Hospital and Tumor Institute, University of Texas at Houston. The presentations have been recorded by that University's Cancer Hospitals physicians as well as other eminent scientists.

The Professional Education Committee, American Cancer Society, is pleased to provide this new service as part of its program of continuing education for the medical and allied health professions.

A catalogue listing the subjects and procedure is available to any physician, dentist, nurse, medical, dental or nursing student upon request.

Contact: American Cancer Society, Ohio Division, Inc., 1367 East Sixth Street, Cleveland 44114.

## WHAT TO WRITE FOR

**Second National Symposium on Child Abuse**—A collection of papers presented at the national meeting last year; 60 pages; \$1.00. This is one of a number of booklets and pamphlets available from the American Humane Association, Children's Division, P. O. Box 1266, Denver, Colorado 80201.

**The Dying Person and the Family**—This is No. 485 in the Public Affairs Pamphlet series dealing in lay terms with health and science, family relations, social and economic problems, race relations, etc. This one is written by Nancy Doyle and addresses itself to developing ways of coordinating care for dying patients and counseling for their families. With this, as with all similar pamphlets, the physician may wish to review a copy before he makes it available to his patients. Available for 35 cents from Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

**Orthopedic Surgery, Zone of the Interior**—This is one volume in a series on Surgery in World War II, being part of a larger series prepared by the Historical Unit, U. S. Army Medical Department. More than a thousand pages of illustrated text is well indexed. Discussion pinpoints many causes of injuries in training, parachute jumping, etc., as well as orthopedic management. The book is for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price \$12.25 (Buckham).

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The University of Kentucky at Lexington is offering several postgraduate courses this fall, among them the following: "Nephrology for the Practicing Physician," September 21-22; "Changing Concepts and Methods in the Practice of Cardiology," October 1-3; and "The Fourth Family Medicine Review," October 7-13. For details contact Ronald D. Hamilton, M.D., Director, Continuing Medical Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

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Ms. Hazel J. Lewis, formerly assistant executive director, has been appointed executive director of the Woman's Auxiliary to the American Medical Association. Executive offices are in the headquarters building of the AMA, 535 N. Dearborn Street, Chicago, Illinois 60610.



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## JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products and let them know that you see their advertising in *The Journal*.

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Rates: 50 cents per line. Minimum charge \$1.00 for each insertion. Display classified, \$1.00 per line. (9 lines to the inch) Prices cover the cost of remailing answers. Forms close the 8th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal  
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

OHIO, FAIRFIELD. Space available in modern Medical Building, 15 miles from Cincinnati. General Practitioner and Specialist needed. Reply to Box 616, c/o The Ohio State Medical Journal.

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio. Phone 271-0291.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

VACATION CONDOMINIUM — New Smyrna Beach, Fla. — just south of Daytona and away from the crowds, but enjoying the same beautiful beach. Two bedrooms, 2 baths, wall-to-wall carpeting, completely and tastefully furnished including linens, color TV and dishwasher. HEATED POOL, and sauna. \$400 per month. For reservations or further information, contact Wm. W. Conner, M.D., 517 Lakeshore Dr., Eustis, Florida 32726. Phone 904-357-5715.

WANTED — General Practitioners. Are you tired of the rat race? There is a great need for your skills in the modern day Mental Health field. Please consider working at a swinging Mental Health Center in Southeastern Ohio in an active college town. For a licensed G.P., the minimum starting salary would be \$20,592 plus additional pay for any overtime above the usual 40 hour work week. Fringe benefits include 2 weeks vacation after 1 year duty, accumulation of sick-leave time, a 50-50 pay basis for Comprehensive Medical Insurance coverage and paid Life Insurance on a graduated scale after 1 year service. Many opportunities for continuing education and for advancement. Generous meeting and travel time. NO OVERHEAD. If at this point you need further information, write: Superintendent, Athens Mental Health Center, Athens, Ohio 45701.

FOR SALE: Physicians Examining Table; Burdick EKG Machine, (late model) and a new Sterilizer. Contact W. H. Miller, M.D., 328 E. State St., Columbus 43215. Telephone 614/221-3743.

GENERAL PRACTITIONER urgently needed: New hospital and a city owned clinic closed! (Doctor retired because of illness). Unmatched hunting and fishing, within one hour of Aberdeen. Excellent income potential for one or two G.P.'s interested in a quiet, clean, friendly community. Immediate practice. Contact: Administrator, Bowdle Hospital, Bowdle, South Dakota 57428. Telephone 605/285-3501.

ASSOCIATES WANTED: Cincinnati based professional corporation seeks full or part-time associates. Openings available in Emergency rooms, community clinics, or Industrial Medical Centers. Medical Health Services, Inc., 5902 Robison Rd., Cincinnati, Ohio 45213. Phone: 513/631-0200.

INTERNISTS, FAMILY PHYSICIANS: Position available on Health Care Teams of physicians and dentists providing family care to inner-city residents of Cleveland. Neighborhood Health Center well organized to allow physicians to provide the best care they are capable of. Salaries competitive, liberal fringe benefits. Address inquiries to David G. Miller, M.D., Medical Director, Hough-Norwood Family Health Care Center, 1465 E. 55th St., Cleveland, Ohio 44103.

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## CLASSIFIED ADVERTISEMENTS

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**WANTED**—Psychiatrists to join a staff of a progressive and active Mental Health Center with heavy emphasis on Community Services but with a crying need to improve the services for those patients who must remain behind. Starting salary range for a board eligible psychiatrist would go from \$23,338-\$26,312 depending upon background. Fringe benefits include 2 weeks vacation after 1 year duty, accumulation of sick-leave time, a 50-50 pay basis for Comprehensive Medical Insurance coverage and paid Life Insurance on a graduated scale after 1 year service. Many opportunities for continuing education and for advancement. Generous meeting and travel time. **NO OVERHEAD.** If at this point you need further information, write: Superintendent, Athens Mental Health Center, Athens, Ohio 45701.

**EMERGENCY ROOM PHYSICIAN** — Accredited 280 bed progressive general hospital in beautiful Huntington, West Virginia; excellent income and working conditions; send resume to Assistant Administrator, Cabell Huntington Hospital, 1340 Sixteenth St., Huntington, West Virginia 25701.

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**OFFICE SPACE FOR RENT:** 1150 sq. ft. in Centerville, Ohio. If interested, contact 513/885-7671.

**OHIO MED. LIC.** Prerequisite to qualify for full or part-time **STAFF PSYCHIATRIST** interested in community psychiatry. Flexible 40 hr. wk., including lunch hours, does not require night call. 1 mo. pd. vacation, paid sick leave cumulative to 120 days total. Opportunities to attend selected lectures and seminars on clinic time & expense. Limited private practice. Salary to \$33,000, depending upon qualifications. Contact: Dr. Thomas Di Mauro, Dir., Stark County Community Mental Health Center, 618 Second St., N.W., Canton, Ohio 44703 or call collect 216/455-9407.

**ANESTHESIOLOGIST:** Board certified or eligible is desired to join a group of 4 Anesthesiologists and associated Nurse Anesthetist. Practicing in a city, population 70,000, midway between Cincinnati and Dayton, Ohio. Reply Box 682, c/o Ohio State Medical Journal.

**EMERGENCY ROOM PHYSICIAN NEEDED IMMEDIATELY**—Established group of two full time and six part time physicians need third full time man for active emergency service. Incorporated. Salary \$36,000 to \$45,000 for 40-50 hours per week, plus bonus quarterly. Excellent 300 bed general hospital in community of 45,000 only 40 miles from Columbus. Many fine specialists available for help and referral. Please contact: L. H. Miller, M.D. 614-344-0331, Newark, O.

**MEDICAL CLINIC CLOSING**, 501 Market St., Baltimore, Ohio; office equip. appraised by the Wendt-Bristol Co., and E.G. Baldwin & Associates, Inc.; includes EKG, BMR, diagnostic x-ray equip., sterilizer, office furniture, and many misc. medical instruments. Call 614/653-8297 for information or appointment.

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The applicant must either be licensed to practice medicine in Indiana or eligible for such license. This plant's Medical Department normally has four physicians participating in a comprehensive program of occupational medicine in a well equipped and modern medical facility.

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Normal working hours are 8 a.m. to 5 p.m. A wide variety of desirable locations in which to live are available.

Qualified applicants will be invited to this plant to inspect the facilities and confer with the Medical Director. Reply in confidence to Box 686, c/o Ohio State Medical Journal.

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## CLASSIFIED ADVERTISEMENTS

(Continued from Previous Page)

**OCCUPATIONAL MEDICINE**, northcentral Ohio, 40 hour week, \$35,000 first year with immediate corporation benefits, then full partnership. Fine community facilities. Ohio license required. Send C.V. to Box 685, c/o Ohio State Medical Journal.

**VIRGIN ISLAND RENTAL (WATER ISLAND)** Spectacular location, well furnished, available year round, minimum two weeks for responsible couple, includes '72 VW, details: Robert L. Turton, 111 W. Third Avenue, Columbus, Ohio 43201.

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**OFFICE SPACE FOR RENT**: Formerly occupied by physician. Living space available in building. Located between St. Anthony and Mt. Carmel East Hospitals. 3855 E. Broad St., Columbus, O. 43213. Phone: 614/231-8200.

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is driving them apart

## Android®-25 Tablets

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Methyltestosterone N.F. —25, 10, 5 mg.

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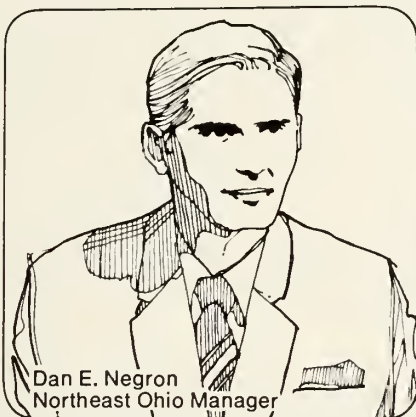
**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosterone. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of cli-

macteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be dis-

continued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples **BROWN** THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057

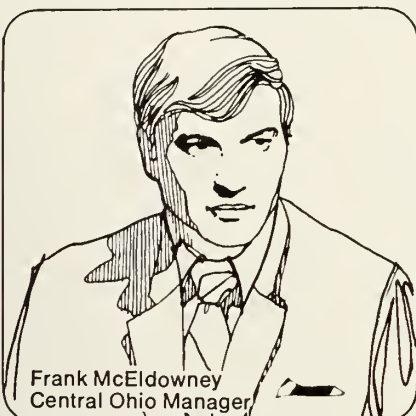




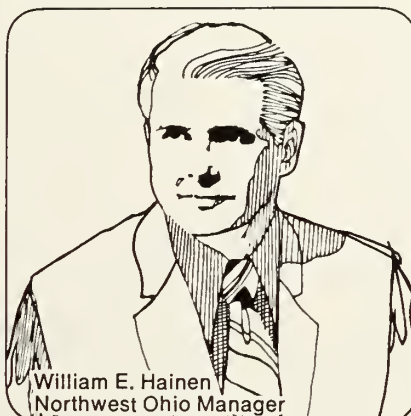
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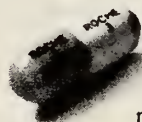
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# How strong must a tranquilizer be for severe anxiety?

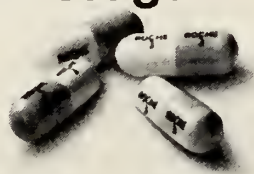
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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.





OCTOBER • 1973  
VOL. 69 NO. 10

# *The Ohio State* MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

THE FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON  
3 - OCT 18/73

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EXCHANGE OFFICE  
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Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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To help you manage excessive psychic tension





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1. Gertler, M. M., et al.: *Geriatrics* 25:134-148 (May) 1970.

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# Health Care in Ohio

## Two Physicians Testify Before Governor's Task Force Stressing Shared Responsibilities of Government, Health Professionals, and Citizens

THE FOLLOWING STATEMENTS were presented August 30 before the Governor's Task Force on Health Care by William R. Schultz, M.D., Wooster, Immediate Past President of OSMA and a member of the Task Force, and by Maurice F. Lieber, M.D., Canton, Sixth District Councilor and chairman of the OSMA Committee on Private Practice.

Governor John J. Gilligan appointed members of the Task Force earlier this year and charged them with studying every aspect of the health care situation in Ohio.

\* \* \*

### Statement by Dr. Schultz:

Health is a privilege and a personal responsibility granted to most of us at birth.

Access to health care is a right which must be available to everyone.

The individual must maintain and protect his health. We call this "individual responsibility."

There is in this nation today great confusion over the terms "access" and "individual responsibility." Too frequently, those who seek to oppose or degrade the present health care system argue that millions of Americans lack access to health care. The access is there. It is the door to health care. It is the responsibility of the individual to enter that door.

Good health cannot be achieved or maintained by legislation alone. A statute cannot promise or maintain the individual's health when that individual refuses to respect his own health. Consider the following:

America's greatest health problems today are caused by air pollution, water pollution, poor housing, addiction to drugs, alcohol and tobacco, obesity, lack of exercise, emotionally undisciplined life styles, poor nutrition, quackery, vehicular and other accidents, drunken driving, and "fadism."

These are serious, complicated problems. However, these are problems that can be solved, to a great extent, by intensive individual education, corrective legislation and individual responsibility.

Positive steps to attain these goals must be a shared responsibility of the health professions, government and every citizen. Workable solutions must be based upon a multiplicity of alternatives to enable effective response to special situations.

Other nations have attempted a single, "cast iron" solution to their health problems, only to have their health care and health system degenerate. A vast majority of Americans still have, and rightfully have, deep faith in their present health care system. Contrary to the opinions of some, they have abiding confidence in the medical profession.

To expect easy solutions or a single system to answer all of today's health needs and problems is dangerously simplistic. We live in a complex society with a multiplicity of wants and needs. We are an imperfect people living in an imperfect society and we must expect some imperfect solutions.

Progress toward our goal must be by evaluation, building on what we have attained and keeping that essential open mind so that ideas and theories may be considered with logic and analysis, so that positive changes are made on the basis of established necessity and not on the quicksands of emotion and political expediency.

Last May, as I concluded my term as President of the Ohio State Medical Association, I offered some guideposts for the assembled elected delegates representing all of Ohio's medical societies and academies of medicine.

I think those guideposts are equally applicable to this Task Force, and I offer them for your serious consideration, to wit:

"There is so much to be achieved and so little time to do it. We can ill afford to dissipate our energies in small groups of regional or philosophical self-interests. To do so subverts much energy from our principal goal . . . and, as always and forever, that goal is . . . the best medical and health care for all the people."

\* \* \*

### Statement by Dr. Lieber:

Ladies and Gentlemen of the Task Force:

I feel greatly honored to be asked to come here tonight to share with you some of my feelings regarding the delivery of health care in this state



and country, now and in the future, and I thank you most sincerely.

I am Maurice F. Lieber, a surgeon in private practice in Canton, Ohio. I graduated from the Johns Hopkins School of Medicine in 1938 and my work has been limited to surgery ever since then. I have served on the Council of the Ohio State Medical Association for the past five years, and have been Chairman of the Committee on Private Practice since it was organized four years ago.

Your assignment is extremely complex, with many facets to consider. Therefore, I propose to make my remarks as brief as possible and then attempt to answer any questions, or enlarge on any of the matters I have alluded to, according to your wishes. H. L. Mencken said, "There is always an easy solution to every human problem: neat, plausible, and wrong." No one in the private practice sector of medicine, I feel sure, believes the American system is perfect. We know it can be improved. We want to improve it. We need your help to improve it. But regardless of what our system is or is not, regardless of what can or should be done with it, what might or can't be done, it must be remembered that practicing physicians are the ones who will be expected to do the job. No one else practices medicine. No planner, no politician, no lay advisor expects to do this, or is able to do it. Yet this need not sound ominous. Doctors have always striven to put themselves out of business, so to speak, by preventive medicine, by controlling diseases, by delivering health. So we feel we surely can sit down together—call us doctors and patients, or call us providers and consumers—surely we can work and plan together in mutual respect and in our respective roles of expertise to keep all phases of life in this great country of ours moving in an ever-improving, constructive direction. This is a far greater thing than our task relating to health alone.

Speaking for doctors in private practice, then, I believe we should concentrate our attention on two things:

1. The quality of medical and health care.
2. The cost of this.

Our attitude is simply that no other system anywhere in the world has provided health care of the quality provided by the traditional private practice system here in America. This, of course, has been hotly debated in recent years. Never has American medicine been surrounded by so many critics and detractors, never have we been so regaled and assailed. It brings to mind the definition of Ambrose Bierce in his *Devil's Dictionary* as he characterized the physician as "One upon whom we set our hopes when ill and our dogs when well." As Harry Schwartz pointed out, two main tech-

niques are employed by critics of American medicine. One is to collect a number of case histories about individuals who have received disastrous results allegedly because of this nation's medical system. The TV media used this technique in the infamous CBS "Don't Get Sick in America," and the more recent NBC "special" entitled "What Price Health?" The other method is to compare American health accomplishments with a Utopian type of health care and then point out our shortcomings, with strong hints that foreign countries such as Britain, Sweden, France, and Germany do, in fact, have these Utopian systems.

I probably would be remiss if I did not tell you how Ohio doctors in private practice feel, generally, about these systems. I was in Britain when the National Health Services was born. It now costs ten times as much each year as Lord Beveridge forecast it would. The quality of care is such that one half of the medical graduates leave the country each year, and for the most part England depends on Indian and Pakistani doctors. Since the advent of the NHS, the number of new hospitals constructed is pitifully small, the waiting period for hospitalization is woefully long and elective operations simply are not done in many areas. My mother-in-law, for example, has waited two years to find any doctor within a fifty-mile radius of her home who had an opening on his panel for her.

Sweden, of course, is different. Touted by so many as first in the liberal models, I was anxious to find out what they are first in. I now can tell you: they are first in drug addiction, first in abortions, first in suicides, first in alcoholism, and first in venereal disease! And to pay for this, 20 percent of all taxes go to the socialized health care scheme. This is the highest per capita rate in the world. In Stockholm alone, there are always between 4,000 and 5,000 people on the waiting list to enter a hospital. Two years have been lopped off the medical curriculum in an effort to obtain more doctors, but a very large number of foreign doctors still have to be imported.

France and Germany have fared no better. In France the socialized scheme operates at tremendous fiscal deficits despite the fact that the system costs the average worker 33⅓ percent of his wages. In Germany the worker pays only 11 percent of his income for the government medical care, which incidentally is administered by private insurance companies. Everything is "free," however, so the average length of hospital stay in Germany is over 20 days as compared with eight and a half days here. As a result, Germans can't get into hospitals, so one out of every six Germans (those who can afford it) buy private health insurance and private hospitalization policies.

This we feel is the pattern wherever medical care has been turned into a kind of public utility—

namely, inferior care, high costs, a shortage of doctors and of hospital beds. It is the old, old story of national health schemes driving up the costs, driving down the quality, and driving out the physicians.

I wish I could present some simplistic shibboleth from the doctors of Ohio. There isn't any. Some people say all we need is more doctors. We have more doctors now than we have ever had; there is one doctor for slightly more than every 700 persons in this country. Last year nearly 15,000 physicians were licensed (for the first time) in the U.S.A.; this is almost three times the number licensed when I took my medical board examinations, a far greater percentage increase than the general population increase. Other people will say it is a distribution problem. Those of us who presently work over 80 hours per week caring for our sick, whether they are able to pay or not, simply feel that doctors, too, are human beings and they will not seek out unpleasant, unhappy places in which to ply their difficult tasks. Medicare and Medicaid have proved at least one thing in clear fashion if nothing else: simply pouring in dollars will not supply medical care.

Yes, doctors feel the name of the game is change. They recognize that our system may need reconstructive surgery. But they feel as Mr. Vene-man put it, "Let's not throw out the baby with the bath water." If this is done, the four R's of socialization that other countries have experienced will result, namely: if the modification isn't Relevant, it will lead to Rebellion, which breeds Rioting, and the system comes to Ruin. The name of the game is change, but not control.

We believe in fee for service. This is being paid for services performed. This is the American

way. There are about 175,000 doctors in this country actively engaged in full time private practice. It is difficult to see how they can be reorganized into 40-hour-per-week workers, approximately half of the time now spent, and expect them to turn out a greater quantity and quality of work.

Yet the feeling of the private practice sector is that every doctor should have the right to select the type of delivery system in which he would like to participate. This could be solo work, partnership, a large or small group, a Foundation, an HMO, or whatever he chooses, just like any American citizen. Similarly, we feel the patient should have the right to choose for himself or herself the type of care he or she would prefer to have; it could be an individual doctor, a group, a prepaid scheme or whatever that person's free choice might be. Financing ought to be worked out in relationship to one's ability to pay. If our poor need help, let us give them help, but let us not destroy the finest system of medicine history has ever known simply so that some may profit, others may have prestige, and the rest may acquire power.

In closing, let me define for you what we consider private practice to be:

Private practice is that system of medical care whereby there is full freedom of choice for the patient in selecting his physician, or group of physicians, and, except in cases of emergency, there is full freedom of choice for the physician, or group of physicians, in accepting his patient. Under such system, the individual physician or group of physicians is responsible for the medical care of an individual patient and the individual patient is responsible to the individual physician or group of physicians, for reimbursement for such medical care.

## Jack L. Ratner

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# California AMA Convention

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**T**HIS YEAR'S Clinical Convention of the American Medical Association promises to be the practicing physician's clinic for continuing education, with 30 postgraduate courses and six general sessions covering new treatments and techniques in most major specialties. A spokesman for the AMA states that there are more informative and stimulating courses than have ever been offered before at an AMA convention.

The place is Anaheim, California, and the dates December 1-4. The planning committee has set up many convention extras for physicians and members of their families. There are charter flights from New York and Chicago, passes to AMA Family Fun Nite at Disneyland, and exotic and fascinating postconvention tours to Hawaii, Acapulco and the Far East.

Watch AMA publications for instructions on

advance registration and hotel and motel accommodations. There is no registration fee for AMA members. Nonmember physicians will pay a \$25 registration fee, and guests of nonmembers, \$5. No general registration fee will be charged medical students, interns, and residents.

Registration fee for 4½-hour postgraduate courses is \$25 and for 9-hour courses, \$40. Medical students, interns and residents pay half price.

The Far East tour is for 15 days; the Hawaii and Acapulco tours are eight days each. Flights to California depart November 30 and return December 6. Transportation is provided from the Los Angeles airport to Anaheim at no extra charge.

For additional information about the tours, contact Helen Meyer, Dept. T, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

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**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

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Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

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Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

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When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, non-habit-forming agent proved effective and relatively safe for relief of insomnia.

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## When restful sleep is indicated

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**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



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# "Prescription drugs – who should determine the maker?"

## Dispenser of Medicine

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## Maker of Medicine

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President  
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Manufacturers  
Association



"Too many doctors are indifferent to the economic consequences of their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by former AMA Chief Executive F. J. L. Blasingame, M.D.

### Doctor, are you indifferent...?

In discussing an anticipated increase in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, MD's have given the impression they are not particularly concerned with the increase in cost of health care to their patients..."

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health care beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other than the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

### Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, the unilateral decision of the pharmacist made in the absence of clinical knowledge of the patient, could expose him to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothing in the pro-substitution argument that offsets these risks.

### The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowledge about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degree puts him at a disadvantage. Most often, a practicing physician will need expert knowledge of no more than 2



ould be an obligation of medical practice...

"Medical societies ought to continue continuing campaigns to point out the substantial savings that could be realized thru deductible insurance for protection for catastrophic illnesses. At the very least, they should, in the patients' interest, question the policies of any insurance organization that raises health care costs by forcing policyholders to buy insurance they may not need or want and probably won't ever use.

"Too many doctors are indifferent to the economic consequences of their decisions. Too many, for example, habitually hospitalize patients for the convenience of the MD. It's no sense to deny such habits exist...

"Doctors, thru their medical societies, have unhesitatingly appealed to their patients for support in the fight against government interference in the private practice of medicine. The public in the past has responded. It's time the American Medical Association and state and local medical societies paid off the debt by decisive action to hold down the cost of medical care."

#### Cost of Drugs

Insurance rates and hospital charges are only two factors in health

care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists are concerned. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

#### Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining

high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

#### APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

*(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)*

30 drugs that he selects to treat the majority of conditions encountered in practice. Moreover, the physician's choice of a specific brand is based on his knowledge of the patient's medical history and current condition, and his experiences with particular manufacturer's product.

Some substitution proponents have argued that the dispensing of a prescription is a simple two-party transaction between the pharmacist and the patient, and that a substituting pharmacist may avoid even a technical breach of contract by simply informing the patient that he is making substitution. I would judge that the courts would be sympathetic toward a pharmacist who substituted without physician approval and who undertook a legal defense that seeks to make the patient responsible for the pharmacist's actions.

#### Reduced Prescription Prices?

Substitution advocates are suggesting to the consumer, and particularly the consumer activist, that reduced prescription prices could follow legalization of substitution. We have seen absolutely no evidence to justify this claim. To the contrary, experience in Alberta, Canada, where substitution is authorized, suggests

the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

#### Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

#### Summary

In short, what the American Pharmaceutical Association advo-

cates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

*(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)*

Pharmaceutical  
Manufacturers Association  
1155 Fifteenth Street, N.W.  
Washington, D.C. 20005



# ROCHE announces new

# BACTRIM<sup>TM</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

## a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

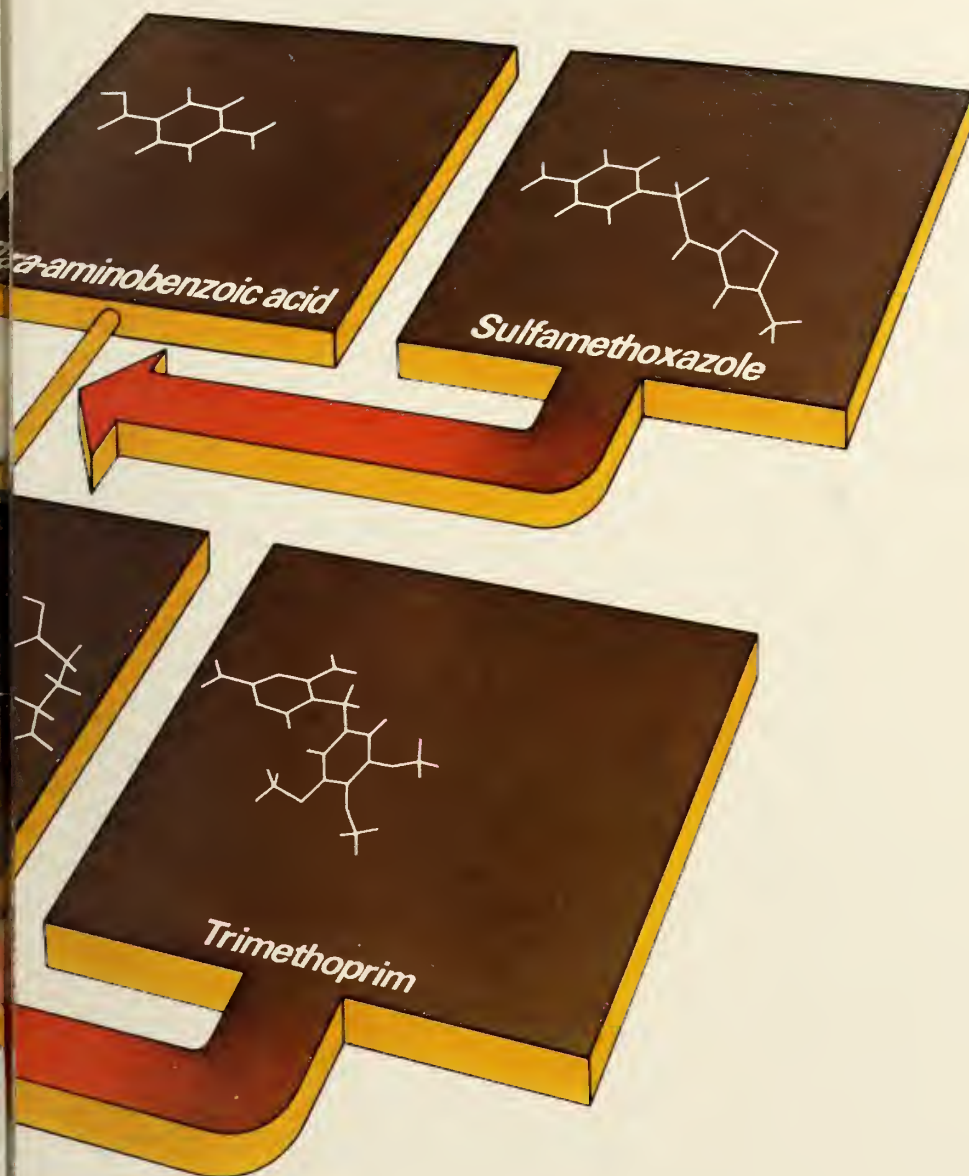
Bactrim is highly effective in the treatment of these infections — primarily pyelonephritis, pyelitis and cystitis — when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

### Bactrim interrupts the life cycle of susceptible bacteria

*Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.*







new **BACTRIM**<sup>TM</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**

Before prescribing, please see complete product information on last page of advertisement.

## Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study\* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

## Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

## Prescribing considerations

**Clinical Limitations:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

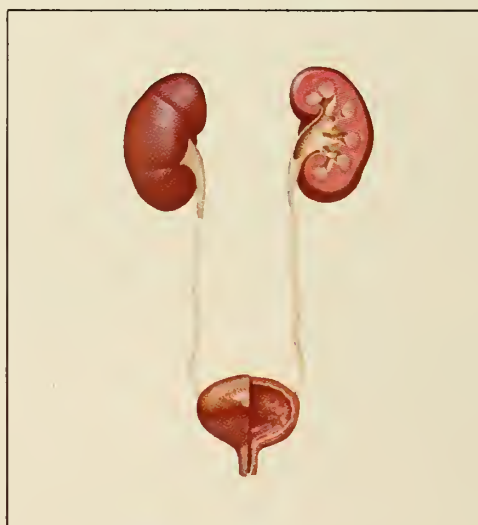
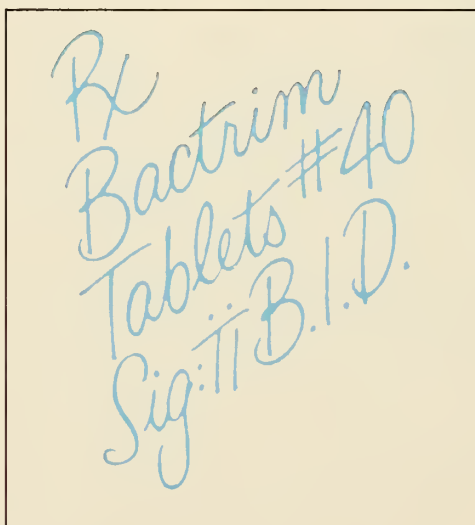
**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

**Warnings and Precautions:** Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Effects:** Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

**Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.**

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110  
†4 patients not available for evaluation at day 10.



**new** **BACTRIM**<sup>TM</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110



Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N<sup>1</sup>-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

| Representative Minimum Inhibitory Concentration Values<br>for Bactrim-Susceptible Organisms<br>(MIC—mcg/ml) |                       |                           |                           |            |
|---|-----------------------|---------------------------|---------------------------|------------|
| Bacteria  | Trimethoprim<br>alone | Sulfamethoxazole<br>alone | TMP/SMX (1:20)<br>TMP SMX |            |
| <i>Escherichia coli</i>   | 0.05—1.5              | 1.0 —245                  | 0.05—0.5                  | 0.95— 9.5  |
| <i>Proteus spp.</i><br>indole positive  | 0.5 —5.0              | 7.35 —300                 | 0.05—1.5                  | 0.95—28.5  |
| <i>Proteus mirabilis</i>  | 0.5 —1.5              | 7.35 — 30                 | 0.05—0.15                 | 0.95— 2.85 |
| <i>Klebsiella-Enterobacter</i>  | 0.15—5.0              | 0.735—245                 | 0.05—1.5                  | 0.95—28.5  |

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprolthrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration:** Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

| Creatinine Clearance<br>(ml/min) | Recommended Dosage<br>Regimen |
|----------------------------------|-------------------------------|
| Above 30                         | Usual standard regimen        |
| 15-30                            | 2 tablets every 24 hours      |
| Below 15                         | Use not recommended           |

**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

**BACTRIM**™  
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

# Community Health News

## Ohio Department of Health

JOHN H. ACKERMAN, M.D., Deputy Director

### Management of VD Patients

Good clinical management of individual infected patients is essential in controlling the gonorrhea epidemic. The reason for therapy failure in many cases is due to the use of ineffective antibiotics as well as inadequate dosage. The drug of choice in the treatment of uncomplicated gonorrhea (urethral, cervical, pharyngeal, or rectal) is:

Parenteral — men and women — Aqueous procaine penicillin G, 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to the injection. (Studies have shown that this therapy produces cure rates approximating 98 percent and is effective in aborting incubating syphilis).

Patients with known exposure to gonorrhea should receive the same treatment as those known to have gonorrhea. All gonorrhea patients should have a serologic test for syphilis at the time of

diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

**Note:** Long-acting forms of penicillin (such as benzathine penicillin G) which produce low blood levels are contraindicated in the treatment of gonorrhea.

Additional information on therapy and follow-up of venereal disease patients is available through the Ohio Department of Health, Venereal Disease Unit, 450 East Town Street, Columbus, Ohio 43215 (Telephone 614/466-2446).

### Immunization Needs More Attention

Recent historical and serological surveys of immunity levels in two year olds and school enterers in Ohio have shown considerable lack of immunity, particularly for poliomyelitis, rubella, and rubeola.

Physicians are reminded that vaccines are provided to them free of charge by the Ohio Department of Health. We urge your cooperation with public health agencies in attempting to increase the immunity levels in children.



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Source of Supply . . .*

**the Wendt-Bristol co.**

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## Continuing Education Opportunities for Physicians in Ohio

### October

Cleveland Clinic Educational Foundation, 9500  
Euclid Ave., Cleveland 44106.

**Dermatology for the Non-Dermatologist** —  
October 10-11.

**Pediatric Endocrinology** — October 24-25.

**Problem Oriented Practice** — Akron City  
Hospital, 525 E. Market St., Akron; October 17.

Ohio State University College of Medicine, Con-  
tinuing Medical Education Conferences; for  
details contact OSU Center for Continuing  
Medical Education, 410 W. Tenth St., Co-  
lumbus 43210:

**Contact Lense Seminar** — October 18-20.

**Head and Neck Surgery** — October 25-27.

University of Cincinnati College of Medicine  
(CONMED):

**The Range of Normal in Human Behavior** —  
at the Shrine Burns Institute, October  
18-21.

**Hypertension Symposium** — October 24 at  
the Shrine Burns Institute, 202 Good-  
man St., Cincinnati.

**Workshop on Bereavement** — October 29-30  
at the Medical Center.

**Newborn Care** — October 31 at the Shrine  
Burns Institute.

Akron City Hospital, Market & Arch Sts., Akron  
44309:

**Problem Oriented Practice**, October 17, by  
Arnold Littman, M.D.

**Visiting Professor Program**, Department of  
Medicine, Oct. 25-26, William Greene,  
M.D.

Publication deadlines require that no-  
tices of postgraduate courses, in order to  
be published in these columns, must be  
received in *The Journal* office at least 60  
days before the course is scheduled to be  
given.

**Northwestern Ohio Medical Association**,  
annual meeting and scientific session, Holiday  
Inn, Bowling Green, Oct. 31; 10:00 a.m. to 4:00  
p.m.; contact Marjorie E. Conrad, M.D., presi-  
dent and chairman, 15819 Bowling Green Road  
West, Bowling Green 43402.

Courses Sponsored by Medical College of Ohio at  
Toledo; for details contact MCO Office of  
Continuing Education, P. O. Box 6190, To-  
ledo 43614.

**Pulmonary Embolism — Clinical Seminar on  
Emergency Medicine** — at Van Wert  
County Hospital, Van Wert, October 10,  
1:00-5:00 p.m.

**Tissue and Organ Transplantation — Semi-  
nar on Fundamentals of Surgery** — Oc-  
tober 13, 10:00 a.m. to noon; in Room  
G-1 at MCO, Arlington and S. Detroit  
Avenues.

**Water and Electrolyte Physiology — Seminar  
on Fundamentals of Surgery** — October  
27, 10:00 a.m. to noon in Room G-1 at  
MCO.

(Continued on Page 745)

# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."





# M-M-R<sup>\*</sup>

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies.

Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

### MSD suggested immunization schedule for well babies

| Age              | Vaccine(s)  |
|------------------|---|
| 2 months         | DPT (diphtheria-pertussis-tetanus)<br>Oral poliomyelitis vaccine (triple) |
| 3 months         | DPT <sup>1</sup>  |
| 4 months         | DPT<br>Oral poliomyelitis vaccine (triple)                                |
| 6 months         | Oral poliomyelitis vaccine (triple)                                       |
| <b>12 MONTHS</b> | <b>M-M-R (MEASLES, MUMPS AND<br/>RUBELLA VIRUS VACCINE, LIVE, MSD)</b>    |

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

<sup>\*</sup>Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

# M-M-R

(MEASLES, MUMPS AND RUBELLA  
VIRUS VACCINE, LIVE | MSD)

Single-dose vials

No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101-102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however,

has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

**Contraindications:** Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

**Precautions:** Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

**Adverse Reactions:** Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

**How Supplied:** Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID<sub>50</sub> (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID<sub>50</sub> of mumps virus vaccine, live, and 1,000 TCID<sub>50</sub> of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

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## Educational Opportunities in Ohio — *Continued*

### November

**Occupational Medicine and Environmental Health**—2-week full-time course with emphasis on clinical and environmental hygiene problems, coverage of OSHA; November 5 to November 16; tuition \$600; for details contact Sidney Lerner, M.D., Kettering Laboratory, Department of Environmental Health, College of Medicine, University of Cincinnati, Cincinnati, Ohio 45219.

**Toxemia of Pregnancy**—Educational Forum sponsored by the Cleveland Society of Obstetricians and Gynecologists, at the Marriott Inn, 4277 W. 150th Street, Cleveland, November 14, beginning at 3:00 p.m.; guest speaker, Russell DeAlvarez, M.D., Temple University; dinner and evening meeting, 7:00 p.m. with Dr. DeAlvarez continuing the discussion on the same subject. Contact Lester A. Ballard, Jr., M.D., Secretary, Clinic Center, 9500 Euclid Avenue, Cleveland 44106.

**Biomechanics** — Sponsored by American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago 60611; at Case Western Reserve University School of Medicine, November 5-9.

**University of Cincinnati College of Medicine (CONMED):**

**Ophthalmologist for the Generalist** — November 8 at the Shrine Burns Institute.

**Basic Principles of Rhinoplasty** — November 11-14, cosponsored by the American Academy of Facial Plastic and Reconstructive Surgery and the UC Dept. of Otolaryngology and Maxillofacial Surgery.

**Ohio State University College of Medicine, Continuing Medical Education Conferences;** for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

**Industrial Audiometry and Conservation of Hearing** — November 7-9; at Stouffer's University Inn, 3025 Olentangy River Rd., Columbus.

**Vascular Disease** — at Stouffer's University Inn, 3025 Olentangy River Rd., Columbus; November 9-10.

**Pathophysiology of Trauma** — Sponsored by the American Academy of Orthopaedic Surgeons, at OSU, November 14-16.

**Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:**

**Gastroenterology** — November 14-15.

**Akron City Hospital, Market & Arch Sts., Akron 44309:**

**Visiting Professor Program, Dept. of Surgery,** November 8-9, Bruce G. MacMillan, M.D.

**What the Medical Subspecialist Thinks the Primary Practitioner Should Know About His Field,** Nov. 21.

**Visiting Professor Program, Dept. of Pathology,** Nov. 29-30, Stephen E. Ritzmann, M.D.

**Why Should We Control Blood Sugar? —** Youngstown Hospital Association, South Unit, Guest Professor, Manuel Tzagournis, M.D., assistant dean, OSU College of Medicine, Nov. 15, 8:00 a.m.

**Courses Sponsored by Medical College of Ohio at Toledo;** for details contact MCO Office of Continuing Education, P. O. Box 6190, Toledo 43614.

**Acute Gastrointestinal Disorders During Pregnancy — Clinical Seminar on Emergency Medicine** — November 8, at Holiday Inn, Defiance, 4:00 to 9:00 p.m.

**The Multiple-Injury Patient — Clinical Seminar on Emergency Medicine** — November 13, Providence Hospital, Sandusky, 4:00 to 9:00 p.m.

**Water and Electrolyte Disturbances in Surgical Patients — Seminar on Fundamentals of Surgery** — November 3 and 10, 10:00 a.m. to noon, Room G-1 at MCO.

**Blood — Normal and Abnormal Coagulation — Seminar on Fundamentals of Surgery** — November 17, 10:00 a.m. to noon, Room G-1 at MCO.

**Symposium on Ulcerative Colitis** — November 29 at MCO.

*(Continued on Next Page)*



## Educational Opportunities in Ohio — *Continued*

### December

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

Cardiology — December 3.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106.

Advances in Ophthalmology — December 5-6.

Workshop on Fluid and Electrolyte Clinical Problems — December 12 at Jewish Hospital, Cincinnati; and Urology X-ray Seminar — December 13-15 at the Netherland Hilton Hotel; University of Cincinnati College of Medicine (CONMED).

Medical Economics — Akron City Hospital, 525 E. Market St., Akron; December 19.

Akron City Hospital, Market & Arch Sts., Akron 44309:

Visiting Professor Program, Dept. of Ob-Gyn, John T. Queenan, M.D., December 5-6.

Medical Economics, December 19.

Courses Sponsored by Medical College of Ohio at Toledo; for details contact MCO Office of Continuing Education, P. O. Box 6190, Toledo 43614.

Acute Complications Related to The Pill — Clinical Seminar on Emergency Medicine — at Blanchard Valley Hospital, Findlay, December 6, 1:00 to 5:00 p.m.

Blood Volume: Maintenance/Replacement — Seminar on Fundamentals of Surgery — December 1, Room G-1 at MCO, 10:00 a.m. to noon.

Metabolic Responses to Surgery — Seminars on Fundamentals of Surgery — December 8 and 15, 10:00 a.m. to noon, Room G-1 at MCO.



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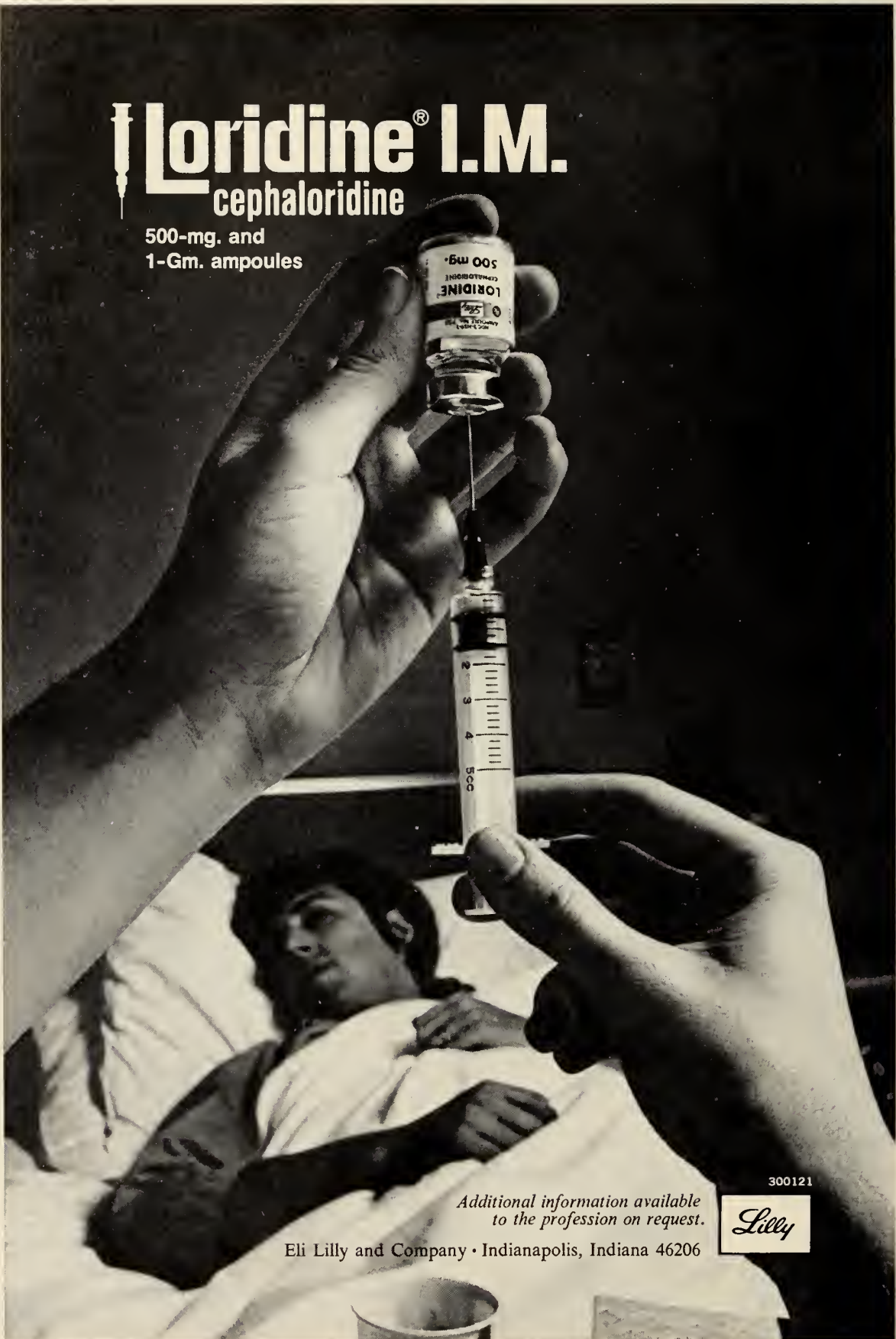
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VOLUME 69

OCTOBER 1973

NUMBER 10

# Vitamin E: Who Needs It?

## I. The Premature Infant and E Deficiency

DAVID K. MELHORN, M.D.

**T**HE RECENT REINTRODUCTION of emphasis on the therapeutic values of vitamin E (tocopherol) in a wide variety of human disease states, generated in part by enthusiastic news media reports and commercial claims, prompts this three-part review of the biologic function, cellular actions, and possible therapeutic roles of this agent in the human being. In this first part, the biochemical nature of tocopherols will be considered, together with some of the known information regarding biochemical function at the cellular level. Following a brief introduction to the chemical actions of the vitamin, a model of vitamin E deficiency in the human, that occurring in the premature infant, will be considered. In the subsequent section, relationships between E lack and various malabsorptive disorders in the child and adult will be explored, and in the final part, the rationality or irrationality of the use of vitamin E

### *The Author*

• Dr. Melhorn, Cleveland, is Assistant Professor, Department of Pediatrics, Case Western Reserve University School of Medicine, and University Hospitals of Cleveland.

therapy for disease states not related to deficiency will be discussed.

### **Biochemistry of the Tocopherols**

Vitamin E is present in a variety of foodstuffs and in a variety of chemically similar forms. Since there is still controversy about the most biologically active form or forms of the vitamin, the alpha-tocopherol compound portrayed in Figure 1 will be considered as representative. It should be noted that the basic tocopherol molecule is modified by esterification with an acetate moiety. Tocopherol supplied in foodstuffs is usually present in a variety of free tocopherol forms, and the ester is generally considered to be removed from the basic molecule by hydrolysis upon entering circulation. One action of vitamin E in biologic systems is that of an anti-

This investigation was supported in part by the Health Fund of Greater Cleveland; National Institute of Health grant FR 87; Ross Laboratories, Columbus, Ohio; and the Elizabeth Sherman Fund.

Reprint requests to Rainbow Babies and Childrens Hospital, 2103 Adelbert Road, Cleveland, Ohio 44106 (Dr. Melhorn).

Submitted March 19, 1973.



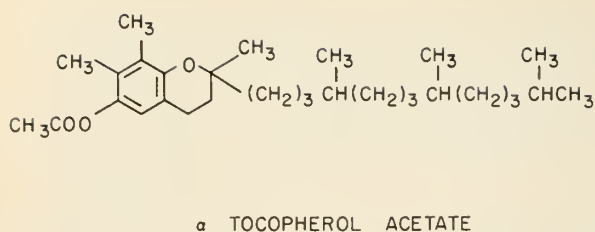


FIG. 1. Representative chemical structure of tocopherol moieties.

oxidant, or antiperoxidant. Its effectiveness in preventing the peroxidation of lipids *in vitro* is easily demonstrated, although the exact mode of this action is not known with certainty.<sup>1</sup> The mechanisms of peroxidation and the protective actions of the tocopherols at the cellular level are schematically represented in Figure 2.<sup>2</sup> It should be observed that peroxidation of the lipid membrane components by peroxide radicals is a continuous process found in many biologic systems. The effects of peroxidation on lipids and cellular proteins are multiple, and these effects can be accentuated either by the increased presence of agents stimulating peroxidation or by a deficiency of the cellular mechanisms normally responsible for detoxification of peroxidants. Although vitamin E deficiency is focused upon here, the normal human red blood cell (RBC) and other cells contain a variety of efficient mechanisms defending against peroxidant agents, eg, glucose-6-phosphate dehydrogenase, glutathione, glutathione peroxidase, catalase, and others, and deficiencies of these substances also may increase the rate and degree of peroxidant damage.<sup>3</sup>

### Causes of Vitamin E Deficiency

It is not the intention of this review to recount the discoveries which led to the identification of vitamin E and vitamin E deficiency states in lower animals. Several points about knowledge gained in animal experimentation are, however, relevant to our discussion of vitamin E deficiency in humans. First, E deficiency in animals such as

the mouse or rat is much more easily produced in the weanling or newborn animal. Second, many of the other cellular antioxidant mechanisms are often decreased or absent in lower animals. It is perhaps for this reason that vitamin E deficiency in animals results in far more serious and generalized effects than in the human. These points may be relevant to such situations as prematurity, as will be later described.

There is also some experimental evidence, both in animals and in humans, that vitamin E plays a role in regulating cellular synthesis of proteins and porphyrins.<sup>4</sup> At the present time, it is unclear whether these functions are related to the antioxidant properties of the vitamin or some other biochemical role, and the significance of such findings in relations to human metabolism is uncertain.

Since relationships between vitamin E deficiency and disease states in the human being remain vague, the minimum daily requirement for intake of the vitamin still has not been firmly established. Various amounts have been recommended, both for children and adults, which have been based upon the average oral dietary intake of tocopherols in the "normal diet," or the comparison of serum tocopherol levels in "normal" populations of individuals with subjects given controlled doses of the vitamin. It is also clear that intestinal absorption, and perhaps utilization, of vitamin E is dependent upon other components in the diet, particularly fats. Although a daily intake of from 5 to 30 international units (IU) has been recommended to maintain vitamin E sufficiency, many investigators prefer to assess requirements in relation to polyunsaturated fatty acid (PUFA) intake. The need for tocopherol appears to rise in proportion to an increased PUFA intake.<sup>5-7</sup>

Although adequate amounts of the tocopherols are present in a wide variety of foods contained in the average adult diet in this country (cereal grains and oils, green vegetables, some meat products, peanut oil, etc.), host factors play an important role in maintenance of E sufficiency. In the following section on the premature infant, for example, it will be seen that vitamin E levels may depend to a greater extent on efficient intestinal absorption than the amount of tocopherols offered in the diet.

### Human Vitamin E Deficiency and Its Consequences: the Premature Infant

The study of the premature infant in relation to vitamin E deficiency began some time ago, not by serendipitous investigation, but by the recognition of possible similarities between newborn animals and the immature infant. Like the weanling rodent, the small premature infant is often vita-

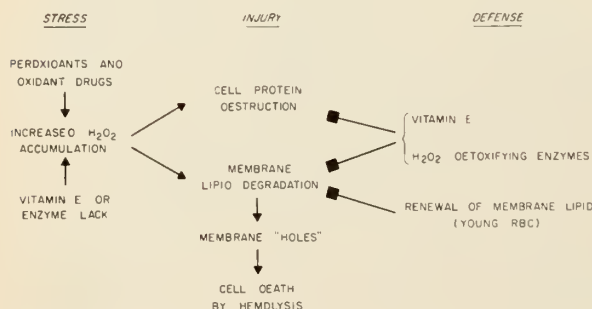


FIG. 2. Diagram modified from Jacob and Lux.<sup>2</sup>

min E deficient (by the commonly accepted definition of a serum-free tocopherol level less than 0.50 per 100 ml) at or shortly after birth when gestational age is less than 36 weeks. Unlike many other substances, it seems apparent that tocopherols are not actively transported from the maternal circulation through the placenta into the fetal circulation. In fact, cord serum E levels in premature and full-term, newborn infants actually have been shown to be significantly lower than in their mothers.<sup>8</sup>

Vitamin E deficiency in the newborn period is rapidly corrected in the first few days of life in the full-term, newborn infant. Although both human breast milk and proprietary formulas in common use contain relatively small amounts of tocopherols, the intestinal absorption of this fat-soluble vitamin is relatively efficient in the full-term infant. In contrast, gut absorption in the premature infant whose gestational age is less than 36 weeks is significantly and persistently decreased, a phenomenon not unexpected in consideration of other studies documenting decreased absorption of fats and other fat-soluble vitamins.<sup>9</sup> As is clearly evident in Figure 3, the full-term newborn is capable of efficient E absorption almost from the time of birth, while the premature infant achieves the same capacity only as he achieves gestational maturity. Paradoxically, therefore, the premature infant is not only most likely to develop vitamin

E deficiency but is least capable of effective absorption of fat-soluble forms of vitamin E during the early weeks of life.

### Laboratory Findings

For many years, vitamin E deficiency in a variety of conditions has been associated with an in vitro laboratory study known as the erythrocyte hydrogen peroxide ( $H_2O_2$ ) hemolysis test. First developed<sup>10</sup> in the 1940's, and subsequently modified in a variety of ways, red cell  $H_2O_2$  hemolysis measures the in vitro lysis of erythrocytes after exposure to  $H_2O_2$ . Results are recorded in terms of percent hemolysis after a period of incubation. In the following presentations of results of  $H_2O_2$  hemolysis determinations, the method of Gordon, et al<sup>11</sup> is employed. Correlation between an abnormally elevated  $H_2O_2$  hemolysis test and vitamin E deficiency (serum vitamin E levels  $< 0.50$  mg per 100 ml) has been well-established, although as previously suggested, increased oxidant stress on the red cell membrane may also result in abnormal erythrocyte  $H_2O_2$  hemolysis, even when serum vitamin E levels are within the normal range. Examples include deficiencies of red cell enzymes involved with detoxification of peroxides or large amounts of oxidant drugs administered to the infant. Even oxygen itself, frequently administered in high concentrations in the early days of life of the premature, may be implicated in increased peroxidation of red cell lipids. The correlation between abnormal  $H_2O_2$  fragility and vitamin E deficiency becomes clear only after the initial four weeks in the premature infant whose gestational age is less than 36 weeks.

Another factor in vitamin E deficiency in premature infants is the unusual composition of lipid components of the red blood cell membrane. The RBC membrane of the premature infant contains, at the time of birth, a greater total lipid content as well as certain lipid fractions when compared with the adult erythrocyte and even with the full-term newborn. As the premature infant develops, RBC lipids decrease to approach "adult" levels at 3 to 4 months of chronologic age. The significance of these progressive changes is not certain. However, it is clear that a relationship exists between serum vitamin E and red blood cell lipids which may reflect the cellular balance between peroxidant and antioxidant agents acting at the membrane level. The degradation of membrane lipid components is also reflected in the in vitro determination of malonyldialdehyde (MDA), a breakdown product of polyunsaturated fats.

### Clinical Findings

The anemia associated with vitamin E deficiency in the premature infant is characterized

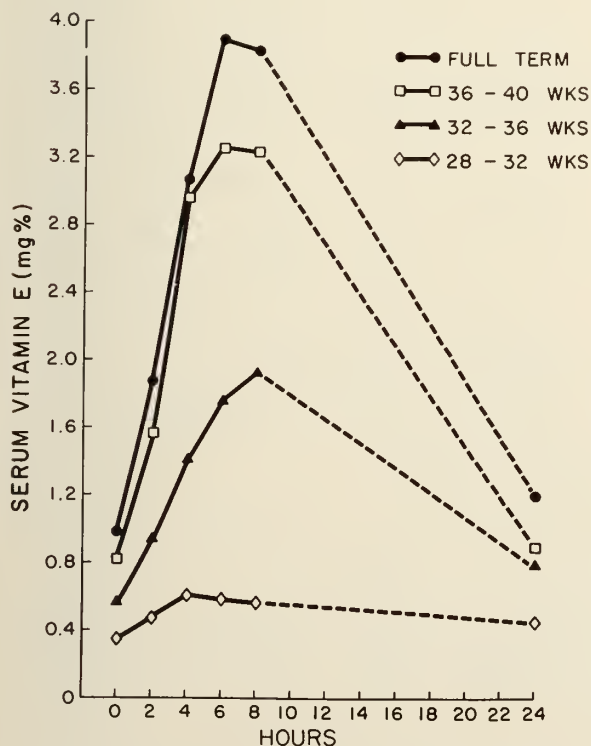


Fig. 3. Vitamin E absorption tolerance curves. Oral tolerance dose in alpha-tocopherol acetate, 25 IU/kg body weight.

TABLE 1. Clinical and Laboratory Findings in Vitamin E-Deficient Premature Infants

| Clinical Features                    | Laboratory Findings                                |
|--------------------------------------|--|
| 1. Gestational age 28-36 weeks       | 1. Serum vitamin E decreased                       |
| 2. Chronologic age 4-8 weeks         | 2. RBC $H_2O_2$ hemolysis increased                |
| 3. Anemia                            | 3. RBC MDA increased                               |
| a. Proportional fall in hgb and hct. | 4. RBC survival decreased                          |
| b. Reticulocyte count evaluated      | 5. RBC membrane phospholipids relatively decreased |
| c. Pyknocytes on peripheral smear    | 6. Active bone marrow erythropoiesis               |
| 4. Thrombocytosis                    | 7. Adequate iron stores                            |
| 5. Peripheral edema*                 |  |

\*Reported in some studies.

by a number of clinical and laboratory findings reported independently by several investigators.<sup>12-14</sup> These findings are reviewed in Table 1. The clinical syndrome is best typified by the following representative case history.

A black male infant, birth weight 1180 gm, gestational age 30 weeks, was transferred to Rainbow Babies and Childrens Hospital at 24 hours of age. Initial hematologic data included hemoglobin value 14.9 gm per ml; hematocrit reading of 49 percent; blood type O Rh+; and direct Coombs test negative. During the first three days of life, the infant manifested mild signs of hyaline membrane disease but improved rapidly. During the next six weeks, weight gain was satisfactory on a standard infant formula and there were no further demonstrable illnesses. The hematologic data gathered during this period are illustrated in Figure 4.

As he reached the chronologic age of 6 weeks, the infant became progressively more anemic, while during the same period, the reticulocyte count rose. Peripheral RBC morphology at age 6 weeks was characterized by the presence of large numbers of pyknocytes and polychromasia. Platelets were increased on smear. At 8 weeks of age, the infant was started on an oral course of tocopherol acetate in a dose of 100 units per day. His hematologic progress following institution of this therapy is seen in Figure 4.

In observation of a large population of small premature infants fed standard formulas,<sup>14</sup> it is clear that all such infants do not become vitamin E deficient, and that among those who do, not all develop the picture of vitamin E-dependent anemia. The former observation may be explained by the variability of intestinal absorption of fats and fat-soluble vitamins in infants of similar gestational age. The latter may reflect both the adequacy of other RBC antioxidant mechanisms or the lack of oxidant stresses during the period of early development.

### Approach to Therapy

Having alluded previously to the problem of intestinal absorption of fats and fat-soluble vitamins in the small premature infant, it is necessary to evaluate response to vitamin E therapy in light of the capability for absorption of the forms of tocopherol given orally. The paradoxical problem the physician faces in directing E therapy or preventing vitamin E deficiency by prophylactic ad-

ministration of the fat-soluble tocopherols is that they are simply not effectively absorbed. Thus, failure to immediately correct the vitamin E-dependent anemia of the premature infant often represents poor absorption of tocopherol in formula or in separate oral supplements. The approach to maintaining vitamin E sufficiency at this hospital has been to use an oral tocopherol acetate supplement in a dose of 25 units per day starting on the 7th day of life. This supplement has been reasonably successful in infants whose gestational age is greater than 32 weeks but quite erratic in those of less than 32 weeks. Coincidentally, sup-

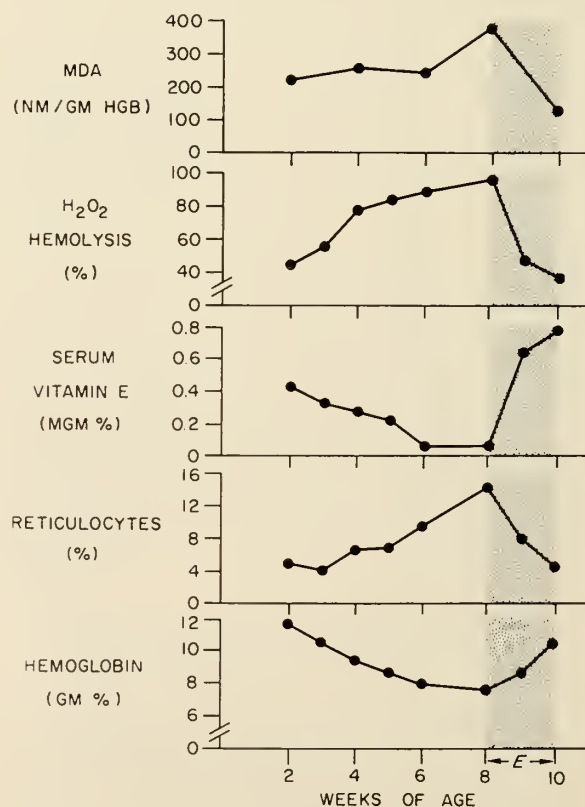


FIG. 4. Hematologic parameters in reported patient prior to and during vitamin E therapy.



plementing the infants with oral iron during the first 8 weeks of life (approximately 8 mg elemental Fe/kg/day) interferes with the intestinal absorption of alpha-tocopherol acetate,<sup>15</sup> and being a peroxidant agent, may add to the peroxidant stress on the vitamin E-deficient red blood cell. There is no evidence, however, that the smaller amounts of elemental iron (2-3 mg/kg/day) present in iron-supplemented proprietary formulas cause similar difficulties.

The effects of vitamin E deficiency on the red blood cell of the premature infant have received greater investigative attention because of the accessibility of this tissue for study. The possibility of adverse effects of E deficiency in other tissues in small premature infants (such as lung and neural elements) has been postulated but not thoroughly explored. The ideal approach to the therapy and prophylaxis of the vitamin E deficiency of prematurity would be a water-soluble form of the vitamin which would be absorbed adequately from the intestine either in medicinal doses or incorporated into proprietary formulas. Such compounds have been studied in other experimental animal and human conditions and are currently being evaluated in the premature infant at this institution.

**Acknowledgment:** I appreciate the technical assistance of Ms. Arlene Pelavin and Ms. Shirley Eisenberg, and the patient efforts of house officers at Rainbow Babies and Childrens Hospital, Cleveland, Ohio.

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## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

This 45-year-old man comes in with a one-year history of right nasal obstruction and foul postnasal drip. He denies having headaches. Physical examination revealed marked erythema and

swelling of his right inferior turbinate. There was no pus present in his nose, however, purulent drainage was noted in his nasopharynx.

What is the most likely diagnosis, how can this be confirmed, and what is the method of treatment?

(See p. 764 of this issue for further information and discussion.)

\*Dr. Miglets, Columbus, is Assistant Professor of Otolaryngology, The Ohio State University College of Medicine.  
Submitted July 12, 1973.

# Small Airway Disease

MUZAFFAR AHMAD, M.D., AND JOSEPH F. TOMASHEFSKI, M.D.

THE SPECTRUM OF chronic obstructive pulmonary diseases makes up one of our major health problems. Chronic bronchitis and emphysema is especially frustrating to the physician because of his inability to appreciably alter the mortality associated with it.<sup>1</sup> Until recently, techniques for diagnosis of chronic obstructive pulmonary disease were lacking. In the 1930's and 1940's, reliance was placed on conventional clinical technics which permitted diagnosis of the illness only in an advanced stage. In the 1950's and 1960's, with widespread use of pulmonary testing, the capabilities of detecting and evaluating patients with chronic obstructive pulmonary diseases evolved and diagnosis could be made with a certain degree of accuracy with some differentiation of entities. More recently, considerable technics have developed which has made it possible to detect chronic obstructive pulmonary disease at a much earlier stage and at a time when it may be reversible. One of the important areas has been the recognition and implication of small airway obstruction in the disease initiation and progression.<sup>2</sup> Small airways are defined as the bronchioles with an inside diameter of less than 2 mm.

## Pathophysiology

It has been well demonstrated by various investigators in both man and dog using retrograde catheters that small airway resistance forms only a small percentage (25 percent) of total airway resistance.<sup>3,4</sup> It is evident, therefore, that small airway resistance may be markedly increased with a relatively insignificant effect in total airway resistance. This is probably what happens in patients with chronic bronchitis and asthma who do not have significant emphysema but have marked ventilation perfusion inequality.<sup>5</sup>

The pathologic changes in small airways in obstructive lung disease have been described by Reid and others.<sup>6</sup> The involvement of terminal

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parts of air passages and the increase in goblet cells along with the presence of inflammation and obliteration of lumen in these patients has been well demonstrated. Dilatation of small bronchioles and abscess formation also have been reported. Macklem, et al<sup>7</sup> have described a group of patients with a reticular pattern on chest roentgenogram who had airway obstruction and chronic hypercapnia. Examination of the lung tissue in these patients, either by biopsy or at necropsy, revealed inflammation of small bronchi and bronchioles, mucous plugging, narrowing, and peribronchial fibrosis. None had significant emphysema. These morphologic findings seemed principally responsible for the functional derangement. Picken, et al<sup>8</sup> have also presented some physiologic evidence that acute viral infections of the upper respiratory tract cause reversible small airway obstruction. It is intriguing to postulate that repeated viral infections in smokers play a role in the development of obstructive lung disease by an initial onslaught in the peripheral airways. Whatever the exact pathogenesis of obstructive lung disease, it is apparent that small airway involvement may be the early, and sometimes the only, manifestation and may remain so for several years before the full-blown picture of obstructive disease is established. More importantly, these patients may be completely asymptomatic. The cessation of smoking and the

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use of bronchodilator therapy at this stage may reverse or at least arrest the progress of obstructive lung disease.<sup>9</sup>

### Methods of Detection

In view of the importance and potential reversibility of small airway obstruction, it is essential that diagnostic procedures are developed to detect it. The one most commonly used is frequency dependence of compliance.<sup>10</sup> In this test, dynamic compliance is measured at different respiratory frequencies. This is done by introducing an esophageal balloon and making simultaneous recordings of transpulmonary pressure and volume obtained from a volume displacement plethysmograph. In patients with small airway disease, the compliance is frequency-dependent because of some regions of the lung moving out of phase with the others. Occasionally a normal subject will show frequency-dependent compliance but it is completely reversed by bronchodilators. The technic, though excellent and probably most sensitive, is quite cumbersome because of the discomfort caused by introduction of an esophageal balloon. Therefore, it needs considerable patient cooperation and is not suitable for routine use. The test is indicative of small airway disease, only if conventional pulmonary function, static compliance, and resistance studies are normal.

McFadden et al<sup>9</sup> studied the pulmonary function of 53 patients with obstructive lung disease whose only abnormalities on routine pulmonary function studies were a reduced maximum mid-expiratory flow rate (MMF) and an enlarged residual volume. Airways resistance, specific conductance, one-second forced expiratory volume, and total lung capacity were all within normal limits. Static compliance was normal but dynamic compliance was frequency-dependent. After treatment with bronchodilators, MMF improved in 21 patients. They postulated that the low MMF depicted an early manifestation of airway obstruction in peripheral bronchioles at a stage when it probably was amenable to therapy.

A method of measuring the relationship between maximum expiratory air flow and lung volume is by obtaining flow-volume curves.<sup>11</sup> In measuring flow-volume curves, a subject inspires to total lung capacity and then expires while flow and volume are recorded. This maneuver is repeated with sequential increase in effort until finally the patient exhales with maximum effort. In analysis of this curve, the flow in the first portion (up to 20 percent) of expired volume is effort dependant while the flow during the remaining part is effort independant. Since the maximum expiratory flow depends on elastic recoil and airway geometry, the plotting of flow-volume curves

might be useful in diagnosis of small airway disease, especially when one looks at the flow rates at low lung volumes. Sufficient data are not in yet about its use as a screening device but it does provide an excellent fingerprint of airway patency and elasticity.

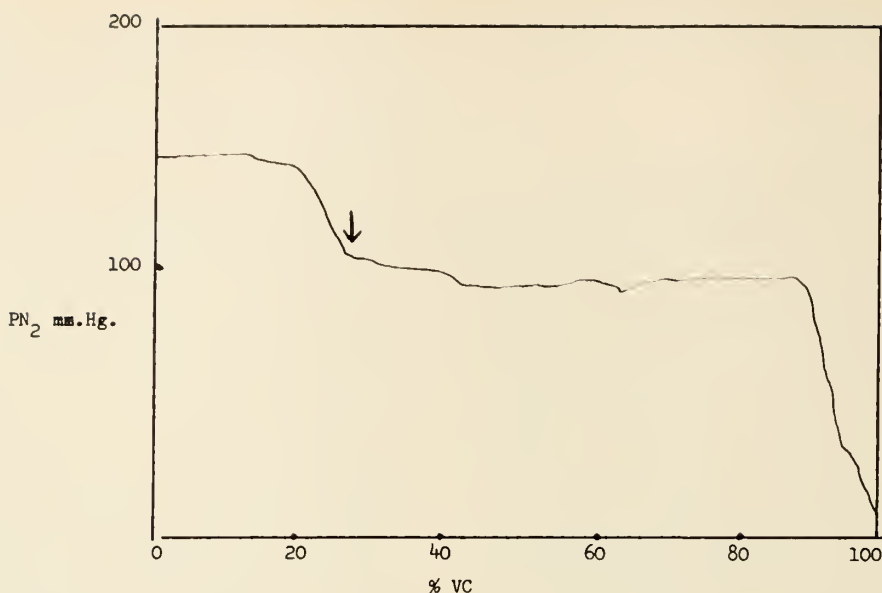
Ventilation-perfusion scanning can be used to study regional lung function.<sup>12</sup> Ventilation-perfusion relationship can be evaluated by radioactive materials, such as argon, xenon and technetium. In patients with respiratory disease where routine pulmonary function tests are normal, ventilation or perfusion abnormality can exist and can be demonstrated by regional ventilation-perfusion mismatching. However, the use of these technics on a practical screening program are too cumbersome and expensive, and furthermore, it is difficult to quantitate pulmonary function deficit in this way.

Tests which measure the closing volume appear to be the most promising.<sup>13,14</sup> Closing volume is the lung volume at which dependent lung zones cease to ventilate, presumably as a result of airway closure. It can be measured by examining the alveolar nitrogen tracings after vital capacity inspirations of oxygen from residual volume. Abrupt changes in the slope of the alveolar plateau signifies the onset of airway closure. The percentage ratio of closing volume to vital capacity increases linearly with age. It is also above the normal limits in some patients supposedly due to small airway disease even at a time when all other pulmonary function studies are normal. In one study, 72 percent of all smokers either had higher percentage ratio of closing volume to vital capacity or had a profound abnormality of expired alveolar plateau indicating the disease of the small airway.<sup>13</sup> Closing volume can also be measured by employing inhalation of the bolus of a foreign gas injected into the air stream at the onset of inspiration. Xenon and argon have been used for this purpose. The results from all technics are similar.<sup>15</sup> Whatever the gas used, it is quite clear that measurement of the closing volume provides a test which detects altered pulmonary function, probably of small airways, much earlier than the conventional lung function tests. The test is simple to perform and very suitable for widespread use (See figure.)

### Proposed Classification of Chronic Obstructive Pulmonary Disease

Various investigators have classified patients with chronic obstructive lung disease into three types.<sup>16</sup> Type A patients are grossly emphysematous and can be diagnosed from x-ray evidence of emphysema. Characteristically, these patients are thin, elderly men with progressive dyspnea and relatively mild or no bronchitis in whom the





Representation of closing volumes. Following a breath of oxygen,  $N_2$  plateau shows gradular linear rise by steeper rise (arrow) representing onset of airway closure in dependent regions, referred to as "closing volume." Oscillations of alveolar plateau are cardiogenic in origin.

resting  $PaCO_2$  is usually normal. Type B patients have relatively minor emphysematous destruction of parenchyma and have a long history of chronic productive cough in whom the  $PaCO_2$  is usually elevated and recurrent heart failure and polycythemia are common. A type X disease (indeterminate) is diagnosed in patients with irreversible airways obstruction, who do not fulfill the criteria for either type A or type B. To these three types, we suggest adding a fourth type and calling it type S after small airways. Type S patients may or may not be symptomatic, have normal pulmonary function studies as performed by conventional methods, but yet have considerable small airway obstruction as indicated by increased closing volume and frequency-dependent compliance. We believe that early detection of type S is important, for it signifies a condition which may be a precursor to types A, B, and X, and it is here that therapeutic measures such as cessation of smoking and bronchodilators may quite conceivably alter the progress of the disease and prevent its crippling complications. (See table.)

To illustrate the type of patient who might have small airway disease, the following case example is presented.

### Case Report

A 28-year-old white male was seen in the outpatient clinic complaining of some tightness and vague discomfort in his chest with mild nonpro-

ductive cough of several months duration. The patient was a nonsmoker and had been in excellent health prior to the present condition. Systemic review was noncontributory. The family history revealed that his father had emphysema and had suffered from tuberculosis in the past. The results of physical examination were normal. The routine laboratory studies, which included complete blood count, urinalysis, and blood chemistries, showed normal values. The chest roentgenogram showed no abnormalities.

The electrocardiogram did not show any significant changes. Alpha I antitrypsin level was 720 micrograms per milliliter, which is in the

Classifications of Patients with Chronic Obstructive Pulmonary Disease

| Type | Clinical and Pathophysiologic Features   |
|------|--|
| A    | X-ray evidence of emphysema, progressive dyspnea, relatively mild bronchitis, chronic heart failure unusual. $PaCO_2$ normal at rest. Lung compliance increased, diffusing capacity impaired, minimal hypoxemia. |
| B    | Minor or no emphysematous destruction of lungs, long history of chronic productive cough, cor pulmonale, recurrent heart failure, $PaCO_2$ elevated, polycythemia, marked hypoxemia.                             |
| X    | Indeterminate, patients who do not fulfill criteria for either type A or B but have irreversible airways obstruction demonstrated by standard pulmonary function testing.  |
| S    | May or may not be symptomatic, normal lung function studies done by conventional methods, but have increased closing volume and frequency dependent compliance. Obstruction potentially reversible.              |

hetrozygous range. The pulmonary function studies revealed normal arterial blood gases and normal diffusing capacity. There was a slight increase in total lung capacity (8.80 liters with a predicted value of 7.50 liters) and residual volume (2.34 liters with a predicted value of 1.49 liters). Forced expiratory volume in the first second was 76 percent of his forced vital capacity (FVC 6.46, FEV1 4.99 liters). The forced mid-expiratory flow (FEF 25 to 75 percent) was 5.67 liters with a prediction of 4.60. A closing volume measurement done on this patient revealed a closing volume over vital capacity ratio of 31 percent. The abnormal finding of increased closing volume in this patient probably signifies early obstruction in the small airways, which in turn is responsible for his symptoms.

### Indications for Testing

On whom should the tests be performed? Obviously symptomatic patients whose routine lung function studies are normal, heavy smokers, Alpha I antitrypsin deficient patients with either homozygous or hetrozygous levels, and patients with bronchiectasis, chronic bronchitis, repeated respiratory tract infections, interstitial fibrosis, and bronchospasm due to any cause should be studied. Closing volumes and MMF measurements are excellent tools for the epidemiologist to employ in population surveys, emphysema research, and air pollution studies.

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# Supply and Demand of Anesthesiologists in Cuyahoga County, Ohio

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WE CAN PREPARE SENSIBLY for the future only if we can forecast demands for and availability of services. Such forecasts also enhance planning for facilities that are related to manpower and require long lead time for realization. Our study was conducted in Cuyahoga County, Ohio, which contains most of Greater Cleveland's population and its 31 general and special hospitals.

The principal phases of the study were:

(1) A survey by questionnaire and interview on bed capacities, operating rooms, surgical procedures, anesthesia personnel, and on the desired manpower level.

(2) Development of models for forecasting the supply of anesthesiologists in Cuyahoga County through 1980.

(3) Development of models for forecasting the demand for anesthesiologists in Cuyahoga County through 1980.

## Survey of the Hospitals in Cuyahoga County

Out of the 22 hospitals covered in this survey, 21 (95 percent) are general, 15 (68 percent) are private, and nine (40 percent) have a residency program in anesthesiology. Of these hospitals, six (27 percent) are large, 13 (59 percent) are medium (150 to 499 beds), and three (14 percent) are small.<sup>1</sup> (It was difficult to obtain access to the

remaining hospitals. The unrepresented 12 percent of bed capacity includes small proprietary hospitals and others wherein few operative procedures are performed.) Some additional data of interest are summarized in Table 1.

The anesthesia directors of these hospitals were also asked two subjective questions. The purpose was to obtain some guidelines for future work and reference. The first question was: "Given the current demand for anesthesia services, how many persons in each category (bottom of Table 1) are desirable in your department?" The desirable manpower and the corresponding percentage changes are presented in Table 2.

The directors recommended increases in the number of anesthesiologists, nurse anesthetists, and residents, and a decrease in the number of interns. They indicated a major requirement for additional nurse anesthetists. The anesthesia directors were asked about the effect that the availability of additional nonphysician anesthesia personnel (nurse anesthetists and others) would have. Of those interviewed, 84 percent thought it would not increase the number of operations performed; that it might result in a major improvement in the quality of care (40 percent); would not result in lower cost to the patient (100 percent); would not increase the income to the anesthesiologist (90 percent); but would perhaps lead to a decreased work load for the anesthesiologist (45 percent).

## Supply of Anesthesiologists in Cuyahoga County in 1980

In the present study, three different supply models were constructed.<sup>2</sup> The object was to predict available anesthesia manpower and contrast these findings with the projected demand for services. Following Dougherty's approach,<sup>3</sup> all the models used per capita income as an independent variable. The concept of linking per capita income to the supply of physicians and medical personnel

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This study was initiated and overseen by a group of Cleveland anesthesiologists representing eight major private and nonprivate hospitals. The physicians are: A. Barnes, N. DePiero, S. Katz, S. Kovacs, H. Kretchmer, K. Potter, B. B. Sankey, and J. Viljoen.

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TABLE 1. Results of Survey of 22 Hospitals in Cuyahoga County, 1971\*

|  | Mean | Standard Deviation |
|--|------|--------------------|
| 1. No. of operating rooms/hospital               | 8    | 6                  |
| 2. Anesthesiologists/hospital                    | 6    | 4                  |
| 3. Anesthetics/hospital/year                     | 6318 | 4250               |
| 4. Anesthetics/operating room/year               | 708  | 78                 |
| 5. Anesthetics/anesthesiologist†                 | 708  | 320                |
| 6. No. of beds/anesthesiologist                  | 62   | 22                 |
| 7. No. of beds/operating room                    | 47   | 26                 |
| 8. No. of hours worked per week/anesthesiologist | 63   | 10                 |
| 9. No. of operating rooms/anesthesiologist       | 1.3  | 1.2                |
| 10. Total no. of anesthesiologists‡              | 137  | —                  |
| 11. Total no. of nurse anesthetists              | 40   | —                  |
| 12. Total no. of residents                       | 69   | —                  |
| 13. Total no. of interns                         | 16   | —                  |

\*Total number of beds in the 22 surveyed hospitals is 8,466. According to the most recent survey by the Northeast Ohio Regional Medical Program,<sup>1</sup> in 1968, there were 31 hospitals in the county with a total bed capacity of 9,592. Thus, survey represents 71 percent of hospitals and 88 percent of bed capacity.

†Only for hospitals without nurse anesthetists, residents, or interns.

‡Estimated number for Greater Cleveland is 149. Survey represents over 90 percent of all anesthesiologists.

has weaknesses inherent to any objective forecasting methodology. It can be defended by assuming that any net demand for additional services will increase the cost of care, which can only be borne by the population. In any event, we are seeking correlation and do not necessarily expect to have causality. Increased services will always cost more money, regardless of the socioeconomic arrangement. The most extensive service will always require the greatest outlay by the population whether in direct payment or through taxation.

Model I treats the per capita income of the population as the most important factor affecting the number of physicians in any given region. As the precise number of anesthesiologists in Cuyahoga County was not available, the analysis was carried out for all physicians. In the past, the ratio of anesthesiologists to physicians in the state held almost steady at 0.038 from 1963 to 1969. We, therefore, estimated for the county the number of anesthesiologists to be 3.8 percent of the number of physicians. In this model, the number of physicians in any year was assumed to be related to the per capita income in the population. The per capita income was obtained from the *Statistical*

TABLE 2. Comparison of Present and Desirable Manpower Levels in 1971\*

| Anesthesia Personnel | Present | Desirable | Changes % |
|----------------------|---------|-----------|-----------|
| Anesthesiologists    | 137     | 156       | + 14.0    |
| Nurse anesthetists   | 40      | 73        | + 82.5    |
| Residents            | 69      | 89        | + 27.0    |
| Interns              | 16      | 11        | — 31.2    |

\*Only for 22 hospitals in survey.

*Abstracts of the U.S.*, generated by the U.S. Bureau of the Census and *Statistical Abstracts of Ohio-1969*, prepared by the Department of Economic and Community Development, State of Ohio.

Model II predicts the supply of physicians assuming the existence of an exponential relationship between per capita income in the county and in the nation. The parameters for this relationship were obtained by regression analysis of data for the years 1963 to 1969.

Model III estimated the supply of physicians for the state and then prorated it to the county. The last model assumed exponential growth of the supply of physicians with time. The parameters used were based upon a time-dependent (1963 to 1969) regression analysis.

Data were collected for the years 1963 to 1969.<sup>4,5</sup> The results derived from three regression models up to 1980 are shown in the graph. According to these models, by 1980 the number of anesthesiologists will rise between 12 and 24 percent, increasing from 147 anesthesiologists in 1969 to between 164 and 180 in 1980. According to these predictions, the average annual increase (the resultant of attrition and influx) in the supply is between two and three anesthesiologists per year.

Annually, approximately 20 residents have entered anesthesiology training programs in Cuyahoga County during the last decade. Past experience and the projections suggest that only a fraction of these stay in Cuyahoga County upon completion of their education. Many other communities have far fewer anesthesiologists per physician in general or per capita than does Greater Cleveland. The county with its many educational facilities in anesthesia serves as a training site for other areas of the country.

Demand for Anesthesiologists in 1980

A model based on the number and mix by sex and age of surgical procedures predicted for 1980 was used to formulate the demand for anesthesiologists. First, the population of 1970 was grouped by sex and age distribution and the surgical procedures classified using a standard codification. Matrices of the demand model were developed. Necessary data for the matrices (1970) came from QUEST division of Blue Cross of Northeast Ohio. The QUEST computer system collects and coordinates data on surgical procedures performed in all Cuyahoga County hospitals. The data for the age distribution of the population in 1980 for Cuyahoga were extracted from a report by the U.S. Bureau of the Census. Since it gives no direct projections for population distribution in Cuyahoga County in 1980, projections for the *entire population* in the United States were used and were prorated for Cuyahoga County.

The total number of surgical procedures in 1970 in Cuyahoga County for males was 51,199



and for females (including obstetrics), was 96,299; hence, the total number of operative procedures for both sexes was 147,498. The estimated number of surgical procedures for males in 1980 is 57,666 by Series B and 55,941 by Series E projections. (The series represent different birthrates used by the Bureau of the Census.)

QUEST data in 1970 indicated that the estimated 149 anesthesiologists of Cuyahoga County administered 132,575 anesthetics. (Not all operative procedures required anesthetics.) Accordingly, on the average, 890 anesthetics were administered per anesthesiologist, which is in reasonable agreement with the data obtained by direct interview with anesthesiologists in the country.

Using the above information and projections, we estimate that in 1980 approximately 155,000 anesthetics will be given, assuming no change in the current level of care. Under these assumptions, 176 anesthesiologists will be required in 1980, with each giving about 890 anesthetics per year. These requirements could be met if the predicted growth of the specialty continues as outlined previously.

### Demand for Anesthesiologists Under Uncertainty

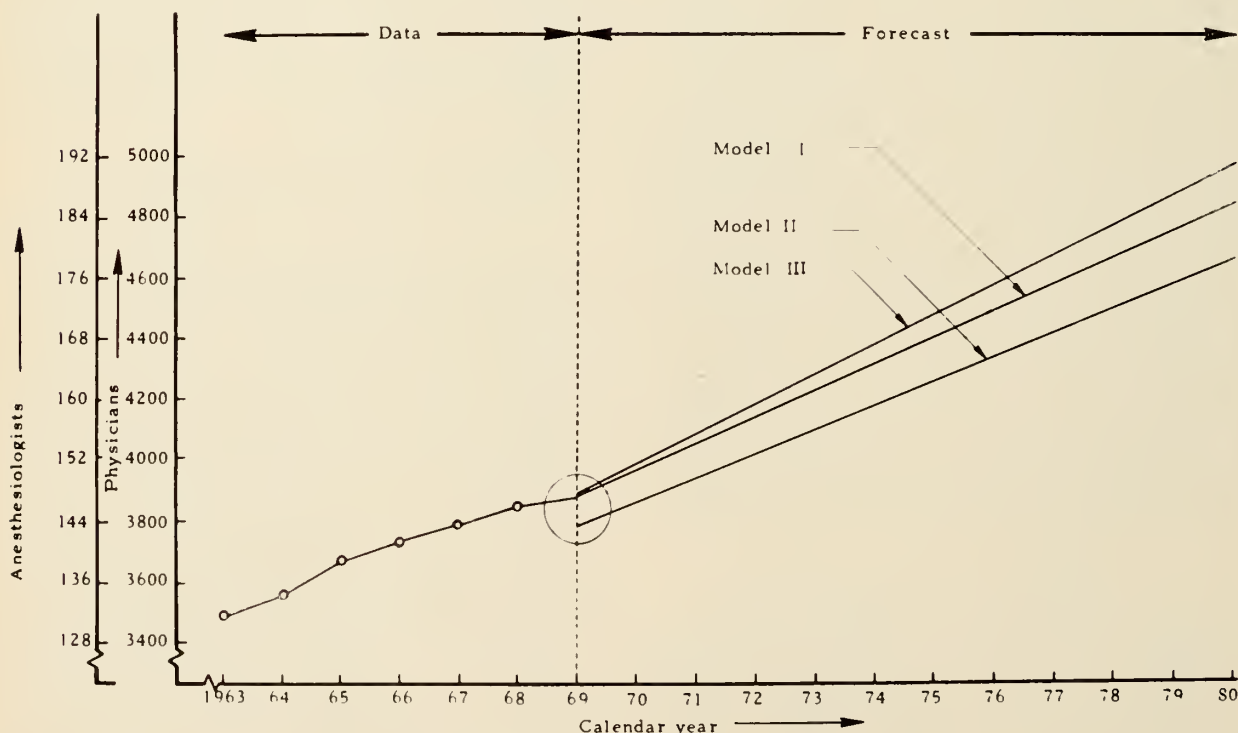
Because of the shortcomings of using simple mathematical projections of the past to predict the

future, and the possibilities of changes in the standards of care as well as in the percentage of the population receiving care, a Delphi exercise<sup>6-8</sup> was conducted as a means of "enriching" the mathematical predictions through the use of expert judgments regarding the future which is inherently uncertain. The Delphi technic is currently in use as a method for eliciting, refining, and integrating the subjective opinions of a panel of experts without compromising the suggestion of any individual. It has three distinctive features: (A) anonymity, (B) exchange of reasons and counterreasons (controlled feedback), and (C) statistical group response.

This approach is useful in reaching a consensus via a series of voting rounds using anonymous feedback. It is possible to reach consensus after no more than four rounds of voting. Consensus is said to have occurred if a certain preset percentage of experts' opinion falls within a given range about a median.

A carefully designed questionnaire is given to the experts who then respond without consulting one another. These responses are collated and analyzed with the median and quartile values of the responses computed and communicated back to all respondents.

The Delphi panel for our experiment included anesthesiologists, surgeons, hospital adminin-



Apparent discontinuity at 1969 occurs because different regression models were used on historical data 1963-1969.

istrators, and educators representing private, county, and university hospitals in Cuyahoga County.

Through several successive rounds of the Delphi exercise, consensus of our experts was reached on each of a set of questions concerning the future. Questions were asked regarding the quality of anesthesia care and the number of anesthetics per capita, projected for 1980. The panel members were also asked to estimate the requirements for future anesthesia personnel assuming improved quality of anesthesia care but no change in the population or in the number of anesthetics per capita.

The Delphi panel members predicted for 1980 a need for about 50 percent more anesthesiologists, about 50 percent more residents and about 70 nonphysician personnel in anesthesia. Through the Delphi exercise, the constraints that contribute to the gap between current and "ideal" manpower levels in anesthesiology were also identified and ranked in order of their importance.\*

Constraints preventing the "ideal" realization of manpower levels† were as follows:

1. Supply of licensed anesthesiologists
2. Supply of residents in anesthesiology
3. Too high a cost to the patient if ideal levels are used
4. Availability of funds to employ additional anesthesia personnel
5. Supply of nurse anesthetists
6. Availability of educational facilities, equipment, faculty
7. Acceptance of changes by professional societies
8. Acceptance of changes by other medical professions
9. Availability of hospital facilities and equipment

The manpower supply and demand projections indicated that most respondents believe that more operative procedures will be performed per capita within a decade. The respondents were not asked to specify whether wider indications for surgery, new surgical procedures, or new segments of the population encompassed would be responsible for the anticipated increase in surgical procedures.

The statistical model could not take into account anticipated developments and it projected a lesser need for 1980 than the reasoned projections by a panel of experts.

### Discussion

Planning for medical facilities and personnel demands predictions. Rather readily available are projections based upon mathematical models tak-

ing past trends and population projections into account. Much uncertainty, however, is introduced by developments that are anticipated but cannot be made the subject of mathematical treatment.

The data presented in the graph indicate that certain mathematical predictions on manpower availability in anesthesiology suggest that by 1980 the population of Cuyahoga County may expect anesthesia services per capita at a level comparable to 1970.

Anesthesiologists in the county, as well as a specially constituted panel of physicians, hospital administrators, and educators, suggested that other perspectives require attention. The anesthesiologists would like to have seen many more personnel in anesthesia in the county during 1971 than were then available. As indicated earlier, anesthesiologists in the county are overcommitted. There is some suggestion, but no unanimity, that additional nonphysician personnel might improve the services the physicians are able to offer today.

Looking into the future, the panel foresaw also greater needs for 1980 than a simple extrapolation appears to forecast. Many factors need to be considered by the planners for tomorrow. Among these are the fact that generally new surgical procedures have increased rather than decreased the demand for anesthesiologists. Two factors are responsible for this: On the one hand, complex surgical interventions, such as requiring cardiopulmonary by-pass, tend to increase the average duration of surgical procedures and, on the other hand, tend to demand more personnel to work with the patient, to operate the complex monitoring equipment, and to provide extensive postoperative care. Some claim that a segment of the population today does not receive optimal care and that expansion of medical services will encompass all segments of the population. This would require additional manpower. If physicians were to lose the incentive to work 60 or more hours per week,\* the demand for personnel would grow.

Planning for a small region such as Cuyahoga County is made even more difficult because the county, with its educational institutions, serves as a source of manpower for other areas. For long-range planning, even for a limited region, national requirements will have to be taken into account.

### Summary

Several models were developed for a projection of supply and demand for anesthesia manpower in Cuyahoga County, Ohio. These projections cover the decade from 1970 to 1980, and are based on the following three approaches:

- (1) Demand for surgical procedures extrapo-

\*Kendall's Coefficient of Concordance  $W=0.34$ .

†Listed in decreasing order of importance as estimated by the panel.

\*Including on-call duty, some anesthesiologists work as much as 90 hours per week.



lated from current and recent past experience.

(2) Regression models based on supply of anesthesiologists and socioeconomic and demographic factors.

(3) Projections using expert opinions generated with the aid of the Delphi method.

All projections show increasing needs for anesthesiologists.

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## Discussion of E.N.T. Case of the Month

(continued from p. 755)

The most probable diagnosis is chronic infection of the paranasal sinuses. Because the ciliary directed flow of the mucous blanket is toward the posterior portion of the nose, mucopurulent material frequently is not visible during anterior rhinoscopy. However, visualization of the nasopharynx will often reveal significant drainage.

The diagnosis can be confirmed by radiographic examination of the paranasal sinuses. The figure reveals the characteristic thickening of the mucosa lining the right maxillary antrum. The opposite side and remaining sinuses are clear.

Initial treatment of bacterial sinusitis should consist of a thorough course of an appropriate antibiotic. A culture of the drainage in the patient's nose and nasopharynx may be helpful, but unfortunately are often contaminated with other nasal bacteria. The usual offending organism is a gram-positive coccus making penicillin or ampicillin a good initial treatment.

During the treatment of the acute sinusitis, oral decongestants are usually not used. Although they may offer some symptomatic relief in opening the nasal airway, they also tend to dry and thicken the mucous blanket hindering the normal physiologic clearance of the nose and paranasal sinuses.

All topical nose drops also have a tendency to stop the ciliary flow and should not be used, the exception being 2 percent ephedrine which effectively will provide decongestion and will not hinder the ciliary action. However, ephedrine nose drops, if used, should not be used longer than three or four days.

Most patients with bacterial sinusitis will respond to this treatment, however, a few resistant



Chronic right maxillary sinusitis. Arrows demonstrate thickening of mucosal lining of sinus. Note appearance of normal left antrum.

cases require irrigation of the sinus to remove inspissated mucopurulent material. This is an office procedure done under local anesthesia. If the patient fails to respond to the antral irrigations, then surgical removal of the thickened lining of the sinus is necessary occasionally.

# Will Ohio Psychiatrists Improve Their Own Professional Community?

THEODOR BONSTEDT, M.D.,\* AND JOHN J. SMITH, M.D.†  
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AS A MOTTO FOR THIS PAPER, we chose a quotation from Dr. Hayden H. Donahue, currently a nominee for the President of the American Psychiatric Association: "If we present a divided image we will one day lose any viable voice either as an organized body or as individual physicians. Our house must be in order or we risk having others order it to the detriment of the psychiatrically ill."<sup>1</sup>

For many years in Ohio, we have witnessed sad conditions in large state hospitals. Among the people who have tried to improve this situation in the 1960's were many from the ranks of our own Ohio Psychiatric Association, notably Dr. Victor M. Victoroff. His speeches and activities have forced us to think about these issues. With completion of the report of the Citizens' Task Force on Mental Health and Mental Retardation of 1971,<sup>2</sup> and with appointment of Dr. Kenneth D. Gaver as a new, knowledgeable, and dynamic director of the streamlined Department of Mental Health and Mental Retardation, circumstances in large state hospitals are showing definite improvement. Among other things, the passage of legislation splitting out Mental Health and Men-

tal Retardation as a Department of State Government has given it the visibility it lacked as a part of an umbrella department with Corrections. Thus freed from competing departmental priorities, needs have been clarified and responded to with increased budgetary support by both the Governor and the Legislature. Many organizational changes have been made in the Central Office in Columbus to make the management more effective. For the first time, there is extensive long- and short-range planning. And so, most things are getting better — except for the issue of attitudes and communication within our own psychiatric community, where we are not practicing the very principles which we say are generally best for optimal performance of human groups and social systems.

### Our Problem

Psychiatrists who work with large state institutions and those who work in private practice do not have sufficient understanding of each others' efforts. To this might be added community health center psychiatrists and the smaller group of academic psychiatrists. On the other hand, there is much criticism on all sides, some of it well-deserved.

This is not a new observation.<sup>3</sup> For a long time, we have hoped that one of our professional associations, at some level of geographic or administrative centralization, would encourage the private sector in psychiatry to help their colleagues working in large state hospitals and, through them, the patients in these hospitals. We all know the conditions there are sad, and any more studies or evaluations of such hospitals can hardly prove anything new beyond shocking the public, which has tended to resist such shock in the past. Having worked in Ohio and elsewhere, primarily in state-supported hospitals but also with some experience in private practice and academic settings,

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Based on a paper presented to the Cincinnati Psychiatric Society, April 18, 1973. From the Rollman Psychiatric Institute and the Department of Psychiatry, University of Cincinnati.

From time to time, we shall publish essays expressing personal opinions on clinical and scientific subjects. It is to be understood that these represent the authors' personal opinions, not necessarily representing or contradicting those of *The Journal* or the Association. Contributions to this feature and letters regarding those published will be welcome, but *The Journal* will reserve the right to reject or to edit both the essays and the responses. — *The Editor*

Submitted May 1, 1973.



we have never observed an effort by private psychiatrists to offer the small time they could volunteer or to work for the fees set by the State, which are recognized by all to be inadequate.

### Attempts at Improvement

Several past presidents of the Ohio Psychiatric Association have privately expressed similar thoughts, but there has been no action in this area. Other psychiatrists, sharing our feelings, have been found in the Community Mental Health Committee of the Ohio Psychiatric Association (OPA), which in its Statement of Goals given to the OPA Council on July 30, 1972, stated in part "academic and private psychiatrists should be encouraged to get to know their local state hospitals through personal contact, and to spend some time working in state hospitals. We commend those state hospitals and those private psychiatrists who have made bold and dramatic efforts to achieve the goals stated above." Except, where are those private psychiatrists who have made these "bold and dramatic efforts"?

Still another group of psychiatrists sharing our feeling has been found on the American Psychiatric Association's (APA) Task Force on the Status of Psychiatric Hospitals. In their report, approved by the APA Board of Trustees in June 1972, it is stated in part: "Professionals in psychiatry should not be too critical of the layman's lack of support when, in many instances, they themselves have done no better. For example, . . . how many district branches of the APA demonstrate either an aggressive interest in, or an aggressive support of the local state hospital facilities? If this support is discussed by the district branch, is it reinforced by day-to-day services and other activities of the members? . . . If the professional psychiatric organizations and the state mental health authority are to collaborate successfully, they will do so only upon the basis of ongoing mutual respect and concern." We would like to add to this: the mutual "respect and concern" should never be a kind of "tokenism" whereby representatives of the state mental health authority are accorded a certain visibility on committees and other groups, with the real influence still being left within the private-academic concern. The APA Task Force's report goes on: "The state hospitals should solicit and receive the fullest possible support from each district branch of the APA and from its members. If the pattern of the 'old' state hospital is not satisfactory, it would change most rapidly and most readily because it receives day-to-day support and help from those psychiatrists in private practice as well as from those of the university and assorted circles. But such help is effective only as part of an ongoing relationship between professionals who respect each other." Unfortunately, the word "respect" is

being all too often translated in actual practice, even by well-meaning psychiatrists, into a type of "patronizing."

Finally, we found more support for this thinking in some remarks made by Dr. Lucy B. Ozarin, National Institute of Mental Health Program Development Officer, who stated: "To improve any part of the mental health care delivery system, you cannot manipulate just that part alone, as is often done with state hospitals in isolation by studying them, castigating them, giving them more money. — you have to make at once coordinated changes in all components of the mental health delivery system, that is including the private practice, community mental health centers, and the academia."<sup>4</sup> The concept of "system" used in this context perhaps deserves some explanation. Just as state hospitals as a "system" have a certain political structure, which is shared in a particular state and to some extent determines the behavior of psychiatrists working in state facilities, similarly private psychiatrists working in the same geographic area have some (less formalized but just as effective) expectations of each other, usually determined to a great extent by recent history of medical and other related situations in a community and communicated through informal channels. Another structured set of expectations applies to psychiatrists working the majority of their time in an academic "system" such as our medical schools in Ohio.

### A Suggested Solution

We have described this issue at length because it seems to us that if any positive, constructive action were to start in this area, the first step would have to be some kind of agreement among psychiatrists at some geographic level, concerning these issues. We hope we can achieve some agreement in one of our local chapters of the Ohio Psychiatric Association, and we realize that this itself may take a lot of debate, constructive only if it is properly organized. Such a dialogue, in order to be productive, would particularly benefit from the initiative of individuals whose feet are in more than one "camp," people who have dual involvements.

Having come to this point, we asked ourselves how the practical application of such ideas might look, assuming response is positive. Since we are dealing with a need for change in attitude, from just criticism to a many-leveled approach and support, we expect that as an exchange of ideas is started through personal contact, various resistances will become apparent. It would be overstating the obvious to tell a psychiatric audience that such resistances would have to be dealt with first. While such resistances derive from various sources in our individual life experiences, we understand it has been found that they can



be corrected by personal exposure and acquaintance on a direct person-to-person level. How long has it been since a local group of cross-sectionally organized psychiatrists (representing all systems of mental health care delivery) met at their local state hospital, not just for a dinner and speech, but for a guided tour of the facility with explanation of the existing needs? If this alternative were chosen, it would have to be followed by a chance for the private psychiatrists to express their feelings — perhaps, about the missing state hospital reports for aftercare of private patients. Many such items would then come into the open which, of course, could mean a heated exchange of opinions and ideas, but most of us know from working with groups that not all heated exchanges are bad. They can be for our own good if properly organized and entered with a feeling of commitment to improve the overall service to the community (and incidentally, also to improve our own chance of survival as practitioners in a fast-changing society). Probably, at some stage of the discussions, there would be sufficient impetus from various subgroups to join efforts in a project aimed at improving an aspect of patient care. At that point in time, a meaningful discussion could be started between psychiatrists (often representing different agencies) concerning the selection and joint work on a particular “target” for improved patient care. Judging by reports in literature and elsewhere, the probability is the highest that such “target area” will be classifiable as an emergency service, aftercare service, services to those crossing the boundaries from one health care system to another, and services to one of several groups in the community for whom little is offered at the present. Once psychiatrists in a local community reached that point, it would mean that the local group has at least partially overcome what Caplan calls “theme interference.”<sup>5</sup> For example, when a fulltime private psychiatrist in Ohio (and a well-trained and respectable fellow, too) once told one of us: “You know, I have this feeling about state hospitals, and you know where it comes from? I was a resident in training at one of these, I came late one night and opened a rarely used side door at my state hospital — and was showered with cockroaches.” Another even more frequent example concerns a patient who is shunted off to a public facility when the insurance runs out. (Less frequently, he may be transferred because of a “sticky transference.”) How should the understaffed, cockroach-ridden state facility feel about being selected as the repository for the poor and difficult cases?<sup>6</sup>

Whether or not a local psychiatric group in Ohio chooses to act to improve this situation, projects are now under way in Cincinnati which will give us all an opportunity to see how much goodwill, and conversely how much difficulty,

exists in this area. The Department of Psychiatry of University of Cincinnati College of Medicine, and the Rollman Psychiatric Institute are attempting a merging operation in terms of training. Furthermore, the department of psychiatry is setting up an emergency evaluation service to cut across a lot of professional lines, and Longview State Hospital is involved in both projects — the experiment is under way.

Cincinnati psychiatrists have long been proud of their “firsts,” such as the Central Clinic and the Child Guidance Home. There is an opportunity here for Cincinnati psychiatrists, as a professional community (and for Ohio psychiatrists elsewhere), to achieve another “first”: to improve the level of liaison, support, and respect of each other’s work in such a way that all patients would benefit across the social and economic lines. A local psychiatric association could initiate such movement in one of several ways. One example would be the creation of a task force with a mandate to study the locally divisive issues in depth and to negotiate for feasible improvements, reporting back to the association as a whole, by a specified deadline. Another possibility would be for a local association henceforth to give the majority of program time to local speakers, panels, and issues.

### Summary

The services performed by psychiatrists to our state population as a whole are rendered less effective due to the existing fragmentation: psychiatrists working in private practice have little knowledge and appreciation of the work of their colleagues in the state system, the community mental health centers, and the medical schools — and the same holds true for the other three groups. Recognition of this serious problem has been quoted from various sources, and a particular solution is suggested, based on the framework of mental health consultation.

Our hope in writing this paper is that not only will it produce a lively discussion, but also that constructive action may follow.

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# Mucoviscidosis

## Report of a Case in a Middle-Aged Adult

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**A**LTHOUGH PATIENTS with cystic fibrosis or mucoviscidosis may grow to adulthood, survival beyond the fourth decade is rare.<sup>1</sup> The oldest living patient in one series was 41 years.<sup>2</sup> The purpose of this article is to report the clinical and pathologic findings in a man in whom the diagnosis of mucoviscidosis was first made at the age of 48 years.

### Case Report

The patient was admitted to Riverside Methodist Hospital on December 16, 1964 with the chief complaint of noncolicky abdominal pain in the left flank, nausea and vomiting of one week duration. Three days after the onset of pain, he "forced" himself to have a bowel movement and passed a hard stool, followed by loose, foul-smelling, very-light-colored, blood-streaked stool. Two days later the pain, constipation, nausea and vomiting recurred. There was no fever or chills. He had a 30-pound weight loss during the preceding five years and 10-pound weight loss in the last six months despite good diet. Past history revealed frequent respiratory infections (sore throats and chest colds) and persistent sinusitis with chronic postnasal drip since childhood. He had tonsillectomy and adenoidectomy at the age of 19 years. Because of persistent sinus trouble, he moved to Texas at the age of 23. Finding no relief, a year later he moved to work as an office clerk in a molybdenum mine in Climax, Colorado (altitude approximately 14,000 ft.). He became so dyspneic soon after his arrival that he was relieved of his duties on doctor's advice. He then moved back to Ohio to work in the office of Cleveland Diesel Company. At the age

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of 26, he was rejected by the Army for reasons of lung disease of unknown nature detected by x-ray examination. Several subsequent chest roentgenograms revealed the same disease which was suspected as tuberculosis but could not be confirmed. In 1950, at the age of 34 years, he was admitted to The Ohio State University Hospital with a history of cough productive of sputum, and progressive dyspnea of eight years duration, which had become worse six weeks before admission after a bout of upper respiratory tract infection. His vital capacity was 1,800 ml. Chest roentgenograms at this time were interpreted as showing diffuse pulmonary fibrosis more intense at bases, pulmonary emphysema, and early cylindrical bronchiectasis of the left basal segments. A wedge biopsy of a granular-indurated area of the lower part of the left upper lobe was performed; this biopsy was reported as showing chronic bronchitis, emphysema, and areas of ossification unassociated with fibrosis or inflammatory reaction. The patient was told that he had only 50 percent use of his lungs due to chronic bronchitis, emphysema, and calcified lung. Five years later, he had a "blackout spell" due to extreme difficulty in expelling the mucus and coughing up a large amount of sticky sputum. In 1957, he was re-admitted to The Ohio State University Hospital for shortness of breath, sinus trouble, and exertional dyspnea. In view of the known diagnosis of chronic bronchitis with pulmonary emphysema, symptomatic treatment was given. From follow-up x-ray films in 1961 and 1964, it was felt there was a decrease in the calcific nodularity of the lung fields but the other changes remained essentially the same.

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Five years before the last admission, he developed ankle edema and congestive heart failure that were treated with diuretics.

**Family History:** The patient was one of five siblings, four male and one female. One male baby died at birth, the second died of pneumonia at the age of 2 years, the third died at the age of 29 years of some unknown developmental anomaly of the kidney associated with kidney infection. The sister was living but had chronic respiratory problems. The patient's parents were living and well without any known illnesses. The patient was married and had only one male offspring, who is now living and well. There was no history of cancer or diabetes in the family.

Physical examination on the last admission revealed a well-developed, but poorly nourished white male in some abdominal distress. The anteroposterior diameter of the chest was increased and scattered rales and rhonchi were heard over both lungs. The heart was normal in size and had a normal sinus rhythm. The abdomen was distended, diffusely tender, tympanitic, and had minimal tinkling bowel sounds. The liver, kidneys, and spleen or any other masses were not palpable. The abdominal veins were distended. Rectal examination revealed yellow-brown stool and a slightly enlarged prostate without nodularity.

Laboratory studies on admission revealed a leukocyte count of 16,870 per cu mm with 82 percent neutrophils; hemoglobin value was 15.6 gm per 100 ml with hematocrit of 47 percent. Blood urea nitrogen (BUN) was 21 mg per 100 ml. Urinalysis was not remarkable. Stools were positive for occult blood. The serum electrolytes after adequate hydration were: sodium 147 mEq/liter, potassium 4.7 mEq/liter, chloride 97 mEq/liter. Blood glucose was 299 mg per 100 ml. Serum amylase and lipase levels were not elevated. The total serum protein was 4.6 gm per 100 ml with serum albumin 2.8 gm per 100 ml, and serum globulin 1.8 gm per 100 ml. C-reactive protein was 1 plus.

Radiologic examination revealed small bowel loops with fluid levels in the left upper quadrant and much fecal material. A diagnosis of small bowel obstruction of unknown etiology, possibly regional enteritis, was made. At laparotomy the next day, the small bowel was found to be greatly dilated, about three or four times the normal size, due to an impacted, hard bezoar about 4 cm long and 3 cm in diameter. The bezoar was removed by enterotomy at which time a biopsy of the small intestine was obtained. Impacted fecal material was also found in the colon; these were suctioned with great difficulty and removed only partially. The long and extremely edematous appendix was also removed.

The appendix measured 7.5 cm in length and 1.7 cm in diameter. The dilated lumen was filled with a cast-like solid green and brown laminated material. The attenuated wall measured up to 2 mm in thickness and

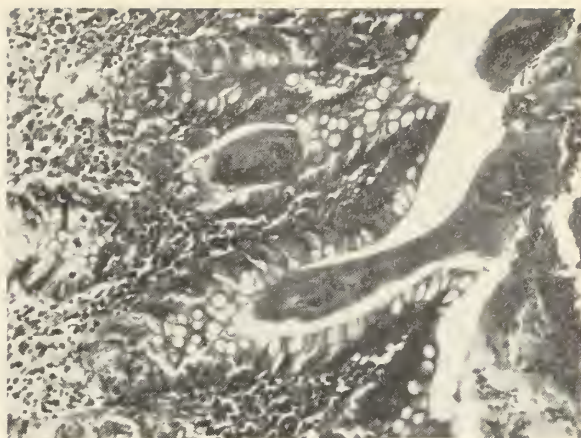


FIG. 1. Appendix. Note "streamers" of mucus in mucosal glands blending with mucus in lumen.

showed on microscopic examination, flattened mucosal folds with attenuated lymphoid tissue and mucosal glands that were distended with "sticky" mucus (Fig. 1). The focally calcified fecal material in the appendiceal lumen was enveloped by mucus, trapped in which were polymorphonuclear leukocytes. The mucus was continuous with the mucus filling the glands at several levels. Biopsy of the small intestine showed similar but more pronounced changes; the surface epithelium of the mucosal villi contained many goblet cells, and the crypts of Lieberkuhn resembled colonic glands due to the increased number of goblet cells. The bezoar contained mostly undigested meat fibers wrapped in mucus. On the basis of these findings, a diagnosis of mucoviscidosis was made.

The first postoperative week was uneventful except for extreme difficulty in expectorating sputum; however, with the administration of iodide, the patient brought up a large amount of sputum. On the eighth postoperative day, the patient developed an acute abdominal catastrophe characterized by abdominal distention associated with diffuse tenderness, rapid fall in blood pressure, vague apprehension, and a slight guarding of the right lower quadrant which was thought to be due to reimpaction. There was abundant leakage of fluid from the stay sutures. Culture of this fluid yielded *Pseudomonas pyocyanea* and *Aerobacter aerogenes*. He continued to complain of abdominal pain, and despite the passing of flatus, abdominal distention associated with decreased bowel sounds continued. The drainage became somewhat fecal in character. The leukocyte count was 24,670 cu mm with 84 percent segmented and 16 percent nonsegmented neutrophils. A sweat chloride test was negative by the then available Fibros Rx filter paper technique, the poor reliability of which has been subsequently recognized. Despite administration of antibiotics and supportive therapy he died on January 3, 1965, eighteen days after admission.

Autopsy disclosed a moderately well-developed, cachectic white male. The pleural cavities contained an estimated 300 ml of fluid bilaterally. The right and left lungs weighed 680 and 1170 grams respectively and showed bronchopneumonic areas involving an estimated 60 percent of lung substance. All the bronchi were found to be irregularly dilated with some reaching cystic proportions. Histologic sections revealed chronic bronchitis with foci of squamous metaplasia, focal bronchiectasis with polypoid projections of the bronchial mucosa, and dilatation of bronchial mucous glands some of which contained inspissated mucus (Fig. 2). The peritoneal cavity contained approximately 1 liter of foul-smelling brown fluid, smelling like fecal material. Greenish-brown, fibrinous adhesions were seen in the peritoneal cavity, and the serosal aspect of the intestines revealed greenish-grey, shaggy exudate. The small intestines were greatly

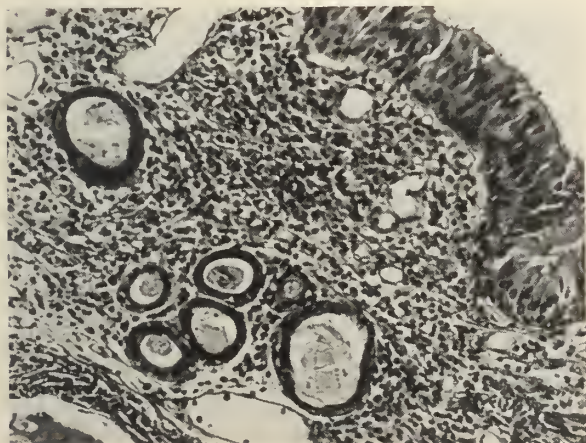


FIG. 2. Bronchial mucosa. Note chronic bronchitis and cystic dilatation of bronchial mucosal glands due to inspissated mucus.



dilated except at the point of enterotomy where the lumen was obstructed by a semisolid, dark, brownish-black mass. The colon was distended with reddish-black sticky, hard material resembling meconium. The rectosigmoid and the rectum did not contain fecal material. The surface of the slightly enlarged liver was covered with greyish-green, fibrinous exudate. The bile ducts were not cystically enlarged. The gallbladder contained bile and a few small calculi measuring up to 6 mm in diameter. The pancreas weighed 130 grams. The pancreatic duct was dilated and could be traced over one-half the length of the pancreas. Several cystic dilations of the ducts (measuring up to 8 mm in diameter) were identified in the substance of the pancreas. These, on histologic sections, were found to be dilated ducts and ductules associated with periductal and perilobular fibrosis (Fig. 3) and extensive interstitial infiltration by fat secondary to exocrine atrophy. The sections of the small intestine showed fibrinopurulent exudate on the serosal surface and large numbers of goblet cells in the mucosa (Fig. 4) similar to the changes seen in the small intestine biopsy at laparotomy. The external genitalia were those of a normal adult male. The seminal vesicles, vas deferens, and epididymides were regarded as unremarkable by the prosector. No histologic examination of these organs was performed.

### Discussion

The history of chronic disabling respiratory disease characterized by repeated respiratory infections, and very tenacious mucus in our patient may also occur in patients with chronic bronchitis. However, the presence of cystically dilated bronchial mucous glands that are filled with inspissated mucus along with the chronic bronchitis and cystic bronchiectasis in our patient is one of the important delayed manifestations of the disease, mucoviscidosis. The intestinal obstruction occurring in older adults has been termed "meconium ileus equivalent."<sup>3</sup> It is due to fecal impaction or similar material and is thought to be due to the combined effects of pancreatic insufficiency and abnormal mucous substances. In our patient, not only was this the presenting manifestation of the disease, but it was also responsible for the fatal outcome due to the impaction following surgical operation,

leakage from the anastomotic site and the operative site, resulting in fecal peritonitis and septic shock. The presence of "sticky" mucus in the mucosal glands of the intestines, and in the fecal masses that distended the lumen confirms the diagnosis. Most importantly, the changes in the appendix, that have been emphasized recently by Shwachman & Holsclaw,<sup>4</sup> were also found in the appendix that was removed at laparotomy. The pancreatic changes characterized by exocrine atrophy and replacement by fat, intralobular fibrosis with cystic dilatation of ductules and patency of the larger pancreatic ducts has been regarded as the late stage of cystic fibrosis.<sup>3</sup>

Several authors<sup>5-8</sup> have reported infertility and aspermia or low fertility in patients with cystic fibrosis due to abnormalities of the mesonephric derivatives, namely, epididymis, vasa efferentia, and seminal vesicles. In our patient at the time of autopsy, we were not aware of these abnormalities and consequently only a cursory examination of the epididymis, seminal vesicles, and vas deferens was done. However, the fact that the patient had fathered a child would favor a normal anatomy of the structures. Detailed questioning of the family of the deceased revealed that he fathered only one child and there were no other conceptions or miscarriages by his wife. This supports the low fertility rate that has been reported in patients with cystic fibrosis. The recent report of Taussig and associates<sup>9</sup> of normal fertility in "a small but appreciable number of males (in the range of 2-3 percent)" with this disease indicates that patients with cystic fibrosis can reach adulthood and can be fertile.

Sweat chloride studies in our patient using Fibros<sup>®</sup> paper (Colab/Laboratories, Inc., Greenwood, Ill.) impregnated with silver nitrate-potassium chromate solution was negative. This result

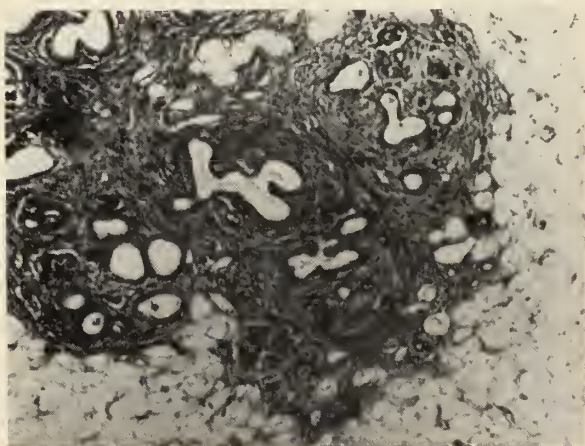


FIG 3. Pancreas. Exocrine atrophy and fatty replacement, dilatation of small ducts and ductules, and intralobular and perilobular fibrosis associated with acinar atrophy are evident.

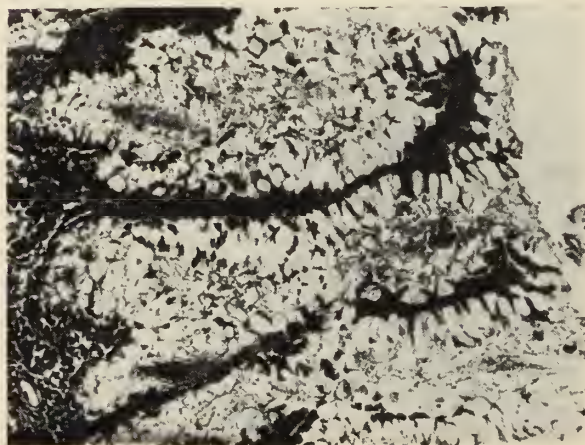


FIG. 4. Small intestine. Tremendous increase in number of goblet cells in mucosal villi are almost bound to each other by mucus.

may reflect the poor sensitivity of this method of testing for elevation of sweat chlorides. It is interesting that the son, who kindly permitted the test for sweat chlorides recently, had sweat chlorides of 61 mEq/liter by the iontophoresis method using the Lancer cystic fibrosis analyzer (Sherwood Medical Industries, Inc., Wisc.) The range established for the laboratory is 10 to 60 mEq/liter. The son, who is now 27 years of age, however, is in good health and has had a son recently.

In conclusion, to our knowledge, this is the oldest patient with cystic fibrosis who labored through life with repeated respiratory infections and finally succumbed to intestinal obstruction from inspissated mucus. The diagnosis of mucoviscidosis was not even entertained or suspected by various clinicians who saw him during his life. This, we believe, is due to the lack of awareness of the occurrence of mucoviscidosis or cystic fibrosis in elderly adults.

### Summary

A 48-year-old man who presented with intestinal obstruction had a diagnosis of mucoviscidosis made for the first time based on histologic features of the appendix and of the small intestinal biopsy. He subsequently died of fecal peritonitis. The gross and microscopic finding at autopsy confirmed the diagnosis of mucoviscidosis.

**Acknowledgment:** The authors thank Dr. Harry Shwachman, Department of Medicine, Children's Hospital Medical Center, Boston, Mass., for critically reviewing this article and for making helpful suggestions.

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# Professional Activities



## What Is a Specialty Section? . . .

## What Is a Specialty Society?

**S**CIENTIFIC SECTIONS of the Ohio State Medical Association and Ohio specialty societies are not one and the same. A scientific section is composed of physicians interested in preparing and presenting at the Scientific Assembly of the Association's Annual Meeting a scientific program. Any member of the Association interested in the subject matter to be presented is welcome to attend any scientific section meeting.

A specialty society is an organization of physicians committed to a particular medical specialty and whose affairs are conducted independently of OSMA.

Article V, Section 1, of the OSMA Constitution and Bylaws states: "Section 1. Annual Meeting. This Association shall hold an Annual Meeting during which there shall be sessions of the House of Delegates, general sessions, meetings of specialty sections and meetings of specialty societies, **all of which shall be open to all registered members and registered guests.**" (Bold type added for emphasis.)

While specialty societies are organized and function independently of OSMA, they are encouraged to conduct their scientific meetings in conjunction with the Annual Meeting of the OSMA and also in cooperation with the scientific sections.

The OSMA Bylaws, Chapter 3, Sections 4 and 5, state: "Section Officers. Each section shall elect a chairman and a secretary to serve until their successors are elected. They shall serve as ex officio members of the Committee on Scientific Work provided for in Section 4 of Chapter 9 of these Bylaws.

"If for any reason a section shall fail to elect section officers at a section session held during the Annual Meeting, such officers shall be appointed by The Council at its first meeting following the close of the Annual Meeting.

Section 5. Section Sessions. Each section authorized by The Council shall hold its session or sessions at times determined by The Council but no section shall be held at the same time as a general session."

Section 7 of Chapter 3 provides that rules "adopted by a section must not be in conflict with the Constitution and Bylaws of this Association and must be approved by The Council before becoming effective.

Neither the Constitution nor the Bylaws provides a specific definition of a scientific section.

Chapter 9, Section 4, provides that the Committee on Scientific Work shall consist of 10 members appointed by the President with approval of the House of Delegates plus the ex officio members, who are the president, president-elect, immediate past president of the Association and the section officers.

Thus, the organization and conduct of a section are delineated by the Constitution and Bylaws. A specialty society, on the other hand, is a society completely independent of OSMA, and determines its own membership requirements and affairs.

While the specialty societies are independent of OSMA, they are continuously encouraged to participate actively in the OSMA Annual Meeting, both through their own identities as well as in cooperation with the scientific sections.



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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

**\*Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings:** Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia ( $> 5.4$  mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently — both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides

are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with anti-hypertensive agents may result in an additive hypotensive effect.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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```
graph TD; A["Patient need for contraception  
Medical history, physical examination  
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```

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A moderately  
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Note: Oral contraceptives are complex medications. As with all medications they should  
be prescribed with discriminating care, and only after reference to full prescribing information.  
For brief summary of prescribing information, please see next page.

primarily on animal studies.



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## **Demulen® Available in 21- and 28-pill schedules**

Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Demulen-28® is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1,2</sup> leading to this conclusion, and one<sup>3</sup> in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of

fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> uptake values; metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov.) 1969.

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**Indication**—Enovid-E is indicated for oral contraception.

The Special Note, Contraindications, Warnings, Precautions and Adverse Reactions listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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Where "The Pill" Began

# Ohio's Four Medical Colleges Received More Than \$42,000 from AMA-ERF This Year

OHIO'S ANNUAL CAMPAIGN on behalf of the American Medical Association Education and Research Foundation is now under way to make it possible for Medical Education Loan Guarantee Programs. Dr. Philip Hardyman, Columbus, is chairman of the Ohio AMA-ERF Committee, which includes councilors of the 11 Councilor Districts of the Ohio State Medical Association.



Philip Hardyman, M.D.

Before launching Ohio's 1973 Annual AMA-ERF campaign drive for funds for Medical Education Loan Guarantee Programs, it might be well to quote a few facts which will be of interest to you.

"The total grants distributed to medical schools through the end of the 1972 contributions is \$23,743,233."

"For the period March, 1962 through December, 1972 a total of 48,700 loans have been made. The total dollar amount is \$55,334,775."

"The four medical schools in Ohio received \$42,214.65 from AMA-ERF in 1973 as follows:

"Case Western Reserve University School of Medicine — \$8,542.22

"Ohio State University College of Medicine — \$14,362.08

"The University of Cincinnati College of Medicine — \$15,778.79

"The Medical College of Ohio at Toledo — \$3,531.56."

All this has been done by the private sector of the economy without government subsidy. This

is an enviable record which can be maintained with the help of Ohio physicians.

But first, here are answers to some questions which you may have concerning the Student Loan Guarantee Fund.

Did you know: That through the Student Loan Guarantee Fund, the struggling medical student may receive direct financial aid?

Did you know: That it now costs at least \$5,000 per year to attend medical school?

Did you know: That your contribution to the Student Loan Guarantee Fund will be held as a guarantee for repayment of loans? For each \$1.00 you give, another \$12.50 will be put to work in loans made by a commercial bank, and as these loans are repaid the money is reactivated to help other students.

Did you know: That the accepted applicant becomes eligible for medical education loans of up to \$1,500 a year? Additional applications may be approved each year so that a maximum of \$10,000 can be borrowed over a seven year period.

Did you know: That since the inception of the Student Loan Guarantee Fund in 1962, 1,868 loans have been made to Ohio medical students for a total of \$2,057,350?

Did you know: That the borrower pays only the established interest rate during his training, and has ten years after completion of training to repay the principal?

The facts stated above are very impressive and the AMA-ERF student loan program has been designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine by utilizing the principal of a security fund functioning as a cosigning agency to make available through community banks relatively large sums of credit at a low rate of interest to medical students.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Hardyman and members of the Ohio AMA-ERF Committee urge Ohio physicians to respond generously in this year's campaign.

YOU, Doctor, can be an important part of this program by contributing now. Where else can you buy so much for so little? Just think, a contribution of \$125 would guarantee a loan for a medical student for one year. Think about it!!



# Outstanding Exhibits Recognized at 1973 OSMA Annual Meeting

**F**EATURES OF THE 1973 OSMA Annual Meeting in Columbus included a very excellent display on the Exhibit Floor of the Veterans Memorial Building including Scientific, Health Education, and Technical Exhibits.

A judging committee selected several exhibits as outstanding and the sponsors were presented certificates of recognition as well as permanent type plaques to be displayed in respective booths and kept as permanent mementos.

A summary of exhibits selected as outstanding appeared in the July issue of *The Journal* and more details on some of these exhibits was published in the September number. Here is additional information on some of the outstanding presentations. Watch for more information in the coming issue.

## Knee Replacement Exhibit Gets Honorable Mention

The exhibit entitled "Geometric Total Knee Replacement Arthroplasty," was given Honorable Mention by the judging committee. The following team members, all associated with the Department of Orthopaedic Surgery, Cleveland Clinic Foundation and Cleveland Clinic Educational Foundation, sponsored the exhibit: Alan H. Wilde, M.D., head of the Section on Rheumatoid Surgery; H. Royer Collins, M.D., head of Section on Sports Medicine; Charles M. Evarts, M.D., chairman, Department of Orthopaedic Surgery; Carl L. Nelson, head of Section on Orthopaedic Research; and Kenneth E. DeHaven, M.D.

The exhibit depicted the indications, contraindications, surgical technique and early experience with the geometric knee replacement arthroplasty. The sponsors at the present time feel that the indications for the operation are those cases of primary or secondary osteoarthritis that are not suitable for osteotomy and those cases of rheumatoid arthritis in which an arthroplasty is indicated. Major contraindications for the operation are active joint sepsis, Charcot's arthropathy, poor soft tissue coverage, absent quadriceps muscle func-

tion, and gross instability or major bone loss.

This procedure was discussed in an article in *Orthopedic Clinics of North America*, April 1973 and in the Spring 1973 issue of the *Cleveland Clinic Quarterly*. Reprints of these articles are available from the sponsors.

## Exhibit on Vasectomy Prosthesis Wins Bronze Award

The Bronze Award in Original Investigation went to the exhibit entitled "Vasectomy Using Implantable Prosthesis," sponsored by Robert T. Bliss, M.D., Cincinnati.

The exhibit presented a prosthesis, a new device reported by the sponsor to replace sutures, clips, clamps, cautery and valves in bilateral partial vasectomy. The prosthesis is reliable not only in maintaining aspermia, but in improving the possibility of successful reversal of the vasectomy. After the device had been used on more than 60 men, the sponsor reported no indications of patient discomfort.

The device consists of two implanted stainless steel cuffs which clamp onto the vas deferens. These are deeply knurled on the inside to prevent slippage, yet are wide enough to prevent cutting through the vas, even with moderate crimping pressure.

A teflon spreader which holds the two cuffs apart and in position is flexible enough to be easily handled and comfortable to the patient.

The sponsor applies the prosthesis to a dissected intact loop of the vas deferens by crimping the cuffs onto the vas a short distance apart. He then incises the segment between the cuffs. He reports that the ends will automatically separate, but they may easily be replaced into anatomical position in the scrotum.

Dr. Bliss reported that postoperative complications have been minimal and that none were actually related to the prosthesis itself. Aspermia is attained in the usual average amount of time and ejaculations.

The sponsor noted that repeat sperm counts at six months have remained at zero. X-ray studies





Dr. William R. Schultz, left, 1972-73 OSMA President, presents the Bronze Award in Original Investigation to Dr. Robert T. Bliss, sponsor of the exhibit, "Vasectomy Using Implantable Prosthesis."

have revealed no cases of slippage of the prosthesis cuffs from the ends of the vas deferens.

The procedure has been reported in *OB-GYN Observer* and in other scientific publications. Dr. Bliss is clinical professor of medicine at the University of Cincinnati College of Medicine.

## Vesicovaginal Fistulae Exhibit Receives Honorable Mention

The exhibit entitled "Repair of Vesicovaginal Fistulae" was given Honorable Mention in the Teaching Field by the judging committee. The exhibit was sponsored by Henry A. Wise II, M.D., of the Division of Urology, Department of Surgery, Ohio State University College of Medicine.

The sponsor summarized the work done on this procedure as follows.

Recurring vesicovaginal fistulae after radiotherapy and pelvic operative procedures is an increasing problem. Radiation inhibits adequate wound healing by causing a narrowing and an obliteration of the blood vessels as well as cellular

damage. The increased tissue destruction makes successful repair difficult, and high recurrence rates are recorded in many of the series reported.<sup>1</sup>

To decrease the morbidity and failure rates, the exhibit advocated the use of nonirradiated tissue transferred to the fistula site where previous operative procedures have been attempted and/or radiotherapy has been administered. Dorsey's description of a transvesical repair of a vesicovaginal fistula makes mention of the peritonealization of the vaginal suture line,<sup>2</sup> and this exhibit carries his work a step farther. An extraperitoneal, suprapubic transvesical approach to the problem is presented, and the use of a pedicled, peritoneal graft or flap is outlined. This flap is interpositioned between the repaired bladder and vagina.

Prior to the use of this procedure in the clinical situation, laboratory work was performed on eight female dogs. Under general anesthesia, a fistula was created between the vagina and the bladder by the use of an electrocautery. After fulguration and perforation, urethral outflow was obstructed for a period of two weeks. Subsequently, urine drained chronically through a vesicovaginal fistula. After a four-six week period of recovery, during which none of the created fistulae had spontaneous closure, all animals underwent opera-

tive repairs using a pedicled peritoneal flap procedure.

A six-month recovery period elapsed, and all animals were sacrificed. An en bloc removal of the pelvic organs was performed, and these were fixed by filling the vagina and bladder with formalin solution, closing the orifices with silk suture, and submerging the organs in a formalin bath for 48 hours.

Sagittal sections of the en bloc section were obtained, and gross and microscopic inspection was performed. The exhibit showed several of these sections, and it is readily apparent that viable tissue exists between the vagina and bladder where the pedicle graft was placed.

The surgical procedure was outlined in the exhibit, and this showed that the bladder is approached through a lower midline or Pfannenstiel incision. Extreme care is taken to reflect the peritoneum intact superiorly off the dome of the bladder. A suprapubic, transvesical approach such as described by O'Connor<sup>3</sup> is used to outline and remove the fistulous tract from both the bladder and vagina. An adequate margin laterally must be obtained so as to insure that viable tissue will be reapproximated in these two organs. Most importantly, the dissection is carried distal to the fistulous tract separating the bladder from the vagina.

The bladder and vagina are closed in at least two layers using 4-0 chromic catgut suture for the mucosa and 2-0 chromic catgut interrupted sutures for the muscularis. A suprapubic catheter is left in the bladder for postoperative drainage.

Traction is placed on the intact peritoneum, and a proposed flap of peritoneal tissue is outlined on either the anterior or the posterior peritoneum, the latter if the peritoneum has been entered during the approach to the bladder. Care must be taken to insure a wide base for this graft, and the width of the tissue itself should be such that the lateral margins may be rolled medially to increase the thickness and the strength of the graft. The lateral margins of the isolated flap are sutured to the midline, and the superior edge of the pedicled graft is drawn inferiorly between the bladder and the vagina past the site of the fistulous tract. The lateral edges of the graft are sutured to the vagina with interrupted sutures of 4-0 chromic catgut.

We have found the use of the pedicled peritoneal graft invaluable as an adjunct to the suprapubic, transvesical approach of vesicovaginal fistula repair. Its use is advocated in all patients who have: (1) a fistula larger than 1 cm. in diameter; (2) a fistula involving or immediately adjacent to a ureteral orifice; (3) a fistula high in the bladder at or above the level of the ureteral orifices; (4) recurrent vesicovaginal fistulae; (5) fistulae sec-

ondary to extension of carcinoma of the cervix, and (6) fistulae in patients who have had radiotherapy to the pelvic organs.

The pedicled peritoneal graft may be taken from either the anterior or the posterior reflexion of the peritoneum, its base always being in the most inferior portion of the pelvic peritoneum. The pedicle of tissue may be reflected from the anterior surface of the uterus if the uterus is still present. The length of the pedicle must be determined by the site of the fistula, and it is possible with this technique to attain an adequate length to interpose viable tissue between a urethrovaginal defect.

The use of the pedicle of viable tissue has a significant advantage in separating potentially overlapping suture lines between the vagina and bladder or urethra. Moreover, the insertion of this viable tissue means that previously irradiated tissue need not be incorporated into the primary surgical repair.

Clinically, this procedure has been used in four patients with vesicovaginal fistulae and there have been no recurrences of the fistula within a six-month period.

## References

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2. Dorsey JW: Transperitoneal closure of vesicovaginal fistulae. *J Urol* 83:404, 1960.
3. O'Connor VJ: *Suprapubic Closure of Vesicovaginal Fistula*. Springfield, Ill., Thomas, 1957.

## Outpatient Office Surgery Exhibit Recognized

Honorable Mention in Original Investigation was voted to the exhibit entitled "Seven Years Experience—Outpatient Office Surgery," sponsored by H. William Porterfield, M.D., John L. Terry, M.D., and Lester R. Mohler, M.D., of Columbus. The sponsors are specialists in plastic surgery.

Following is the background of information represented in the seven years of experience.

The exhibitors presented their experience in a seven year period during which time 7,353 operative procedures were performed in an outpatient office operating room setting. Of these cases 1,823 were performed under general anesthesia and 5,530 under local anesthesia.

In 1965, while designing an office building, they felt that there was a need for an appropriate operating facility that could be utilized by a busy private plastic surgical practice. They recognized



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that many procedures in this field could be done on an outpatient basis if the appropriate facility were available. Furthermore, in so doing considerable numbers of hospital admissions could be eliminated at significant cost savings. In 1965 the principals also were concerned about the possibilities of bed shortages with the onset of Medicare.

In the exhibit, criteria for outpatient local anesthesia office surgery were carefully detailed and the following general headings were stressed: Properly equipped operating room, appropriate monitoring and resuscitation equipment, adequate recovery room facilities, appropriate records. Of the cases under local anesthesia 41.4 percent were for benign skin lesions and 10.5 percent for malignant skin lesions.

The criteria for outpatient general anesthesia office surgery was also detailed by the authors and the following major headings were presented: Proper patient and case selection, trained anesthesiologists, properly equipped operating room, appropriate resuscitation and monitoring equipment, adjacent recovery room, laboratory availability, and appropriate records. Of note in the routine procedures for general anesthesia cases is the precaution that no patient receive preoperative medication. This facilitates a shortening of the recovery period. The patient's preoperative anxiety and concern over the operative procedure is markedly reduced in the outpatient setting away from the hospital environment.

The case distribution under general anesthesia range from 13.4 percent augmentation mammoplasty (245 cases), to face lifts, otoplasties, many scar revisions (16.5 percent), hand surgery cases, including tendon grafts and tendon repairs, Dupuytren's contractures, carpal tunnel syndromes and others (15.7 percent).

The exhibitors stressed the advantages of outpatient office surgery as being a reduction in the costs of care to patient and carrier, convenience to the patient, convenience to the surgeon, and considerable staff efficiency. No major complica-

tions were encountered, no wound infections and no hospital admission were required following these 7,353 operative procedures.

Based on current hospital charges for hospital stay and operating room expenses, a marked reduction in cost is clearly evident. The actual cost of operating the operative outpatient facility for the exhibitors is \$60 per case.

An interesting cost comparison is presented in the following chart:

All 7,353 cases as hospital inpatients:

2 nights at \$91 per night, \$182; plus operating room and related charges, \$105, making \$287 per case or a total of \$2,110,311.

All 7,353 cases as hospital outpatients:

Operating room charges, \$105, plus anesthesia setup, \$15, or \$120 per case, making a total of \$882,360.

All 7,353 cases as office outpatients:

\$60 per case, or a total of \$441,180.

All general anesthesia and surgical fees are excluded from these charges since they are the same in all settings.

The contrast in cost is quite striking when the two extremes of the method are contrasted in dollars. These differences and their savings demonstrated are savings to the patients and to the carriers. It does not reflect the additional savings to patients and their families in reduced work-time loss, cost for baby-sitters, overnight lodging, meals, etc.

The conclusions are that outpatient office surgery is safe, economical, effective and convenient.

The sponsors make two specific recommendations. First, the guidelines for the management and control of office surgery must be rigidly applied. Secondly, such facilities must be managed either by a single specialty surgical group with the close cooperation of a qualified anesthesia group, or it must be managed by a qualified anesthesia group if it is available for general community surgical use.



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Riboflavin . . . 2 mg. • Pyridoxine HCl . . . 3 mg.  
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**INDICATIONS:** As a cerebral stimulant and vasodilator.  
**RECOMMENDED GERIATRIC DOSAGE:** One capsule three times daily adjusted to the individual patient.  
**WARNING:** Overdosage may cause muscle tremor and convulsions.

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\*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from: The Journal of the American Geriatrics Society Vol. XII, No. 6, June 1964.

# Obituaries

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**Blanchard Vincent Antes, M.D.,** Canton; Johns Hopkins University School of Medicine, 1931; aged 77; died August 27; member of OSMA and AMA; practitioner of long standing in Canton where he specialized in obstetrics and gynecology; member of the Brother's Brother Foundation, an organization that sponsored immunization in underprivileged areas and in foreign countries.

**Wilbur Evans Beach, M.D.,** Middle Point; Cleveland Pulte Medical College, 1912; aged 83; died August 12; member of OSMA and AMA; private practitioner in Van Wert County for many years before World War II; served in the Army during World Wars I and II; associated after the war with the Veterans Administration; former coroner of Van Wert County.

**Kenneth Bonnell Browne, M.D.,** Taccoa, Ga.; Western Reserve University School of Medicine, 1933; aged 67; died August 15; former member of OSMA and AMA; practitioner for 33 years in Whitehouse and Toledo before his retirement about three years ago; veteran of World War II.

**Clarence Maurice Douthitt, M.D.,** Cleveland; Ohio State University College of Medicine, 1912; aged 96; died August 25; former member of OSMA; practitioner in Cleveland for more than 50 years; veteran of World War I.

**Richard Joseph Freedman, M.D.,** Cleveland; Ohio State University College of Medicine, 1963; aged 36; died July 29; member of OSMA; practitioner in Cleveland, specializing in internal medicine.

**Charles Jacob Griebbling, M.D.,** Port St. Lucie, Fla.; Ohio State University College of Medicine, 1926; aged 74; died August 3; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner in Galion from 1932 until 1968 when he retired.

**Charles P. Harris, M.D.,** Fresno, Calif.; Eclectic Medical College, Cincinnati, 1935; aged

66; died in mid-August; practiced in Cleves, Ohio before moving to California some 27 years ago.

**Harry C. Harris, M.D.,** Fairborn; University of Illinois College of Medicine, 1927; aged 75; died August 5; former member of OSMA and AMA; resident of Fairborn since 1955 and former civilian physician for Wright Patterson Air Force Base; also associated with the Dayton Mental Health Center.

**James Martin Hindley, M.D.,** Huron; Western Reserve University School of Medicine, 1932; aged 67; died July 10; member of OSMA and AMA; practitioner of long standing in Huron County, formerly residing at Monroeville.

**Nagaraja Honnappa, M.D.,** Bangalore, India; graduate of the Bangalore Medical College, India; aged 27; died August 12 in a railroad crossing accident; second year resident at St. Alexis Hospital, Cleveland.

**John Joseph Kamesis, M.D.,** Cleveland; St. Louis University School of Medicine, 1930; aged 71; died August 14; former member of OSMA; general practitioner in Cleveland for 43 years, and physician for the Veterans Administration in Cleveland for 11 years; veteran of World War II.

**Donald James Marica, M.D.,** Fostoria, Washington University School of Medicine, 1941; aged 59; died July 25; member of OSMA, AMA, and Fellow of the International College of Surgeons; practitioner of long standing in Fostoria.

**Will Wood Moody, M.D.,** Vaughnsville; Western Reserve University School of Medicine, 1951; aged 53; died July 22 in a traffic mishap; member of OSMA, AMA and the American Diabetes Association; general practitioner in the Putnam County area for a number of years.

**Paul Patrick Parker, M.D.,** Wadsworth; University of Illinois College of Medicine, 1948; aged





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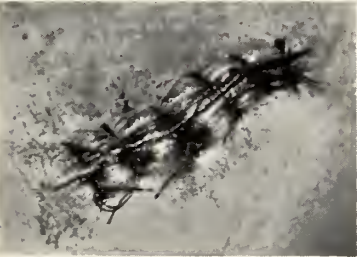
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51; died August 1; member of OSMA and former member of AMA; general practitioner in the Wadsworth area for about 20 years; served in the U. S. Air Force, 1951-1953.

**Milo B. Rice, M.D.**, Pandora; Eclectic Medical College, Cincinnati, 1936; aged 72; died July 19; member of OSMA, AMA, and the American Academy of Family Physicians; general practitioner in the Pandora area beginning in 1935 and Putnam County health commissioner from 1965 to 1971; veteran of World War II.

**John Thomas Read, M.D.**, Columbus; Ohio State University College of Medicine, 1941; aged 57; died August 9; member of OSMA, AMA and the American Society of Clinical Pathologists; Fellow, American College of Physicians; diplomate, American Board of Internal Medicine; practitioner in Columbus for many years; veteran of World War II.

**Victor Roland Turner, M.D.**, Newark; Johns Hopkins University School of Medicine, 1915; aged 86; died July 2; member of OSMA and AMA; retired for a number of years after a practice of long standing in Newark, where he specialized in internal medicine and radiology; veteran of World War I.

**Andrew Allen Winter, M.D.**, Toledo; Royal Hungarian University of Szeged, 1934; aged 65; died August 26; member of OSMA and AMA; Fellow, American College of Cardiology; practitioner in Toledo for about 33 years; served in the U. S. Air Force during World War II.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during August. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

#### BUTLER

Robert J. Lerer  
Fairfield

#### CUYAHOGA

Rafiq A. Hussain  
Cleveland  
Michael R. Rose  
Cleveland

#### DEFIANCE

Kenneth W. Blissenbach  
Defiance  
Subash Mathew  
Defiance

#### FRANKLIN (Columbus, except as noted)

Karl W. Kumler  
Jae K. Lee  
Worthington

Richard P. Lewis  
Carl S. Mankowitz  
Alan G. S. Resor  
Edward D. Sparks  
Gerald J. Tornabene  
Nipapan Wattanasarn  
Claire V. Wolfe

#### LAWRENCE

Pacifico D. Dorado  
Irononton

#### MARION

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# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

IN A SENSE, this year's Fall Conference will be something of a whole new ball game. The change will not be so much in the workshops themselves as in the NUMBER and WHERE of them. For the first time, there will be four regional workshops rather than just the one usually centered in Columbus. Here is how Fall Conference is scheduled this year:

October 22, Findlay, the Imperial House Motor Inn; October 23, Youngstown, the Sheraton Motor Inn; October 30, Dayton, the Dayton Convention Center; October 31, Cambridge, Salt Fork Lodge.

"We're coming to you," explains Mrs. Karl Ulicny, state president. "We feel that if we can bring our Conference and Workshops closer to home, so to speak, we'll get greater participation." In the past, the "pitch" was made essentially to county auxiliary officers and chairmen. This year, every auxiliary member is invited to come and listen in and participate. "After all," commented Mrs. S. J. Glueck, state president-elect, in charge of the Fall Conferences, "today's auxiliary member not holding a specific office or chairmanship may be tomorrow's officer or chairman."

State officers and state chairmen will form a travelling team, setting up identical programs at all four areas on four different days. Here is the workshop format in detail:

8:30 a.m.—Continental breakfast and Registration (8:30 to 9:30 a.m.)

9:30 Opening Session—Mrs. S. J. Glueck presiding

9:45 Leadership Training—Mrs. Louis Loria

10:15 Fund Raising—Mrs. Karl Ulicny

- 10:30 Three Concurrent Workshops  
AMA-ERF—Mrs. Henry Holden and Mrs. H. R. Hunt  
Publicity—Mrs. S. L. Meltzer and Mrs. Robert Holladay  
Health Education—Mrs. Armin Melior
- 11:30 District Fellowship (get-together of district directors with their counties)
- 12:00 noon Luncheon
- 1:10 p.m. Three Concurrent Workshops  
Health Services—Mrs. Albert May  
Health Manpower—Mrs. Ernest Fox  
Legislation—Mrs. S. B. Pfahl
- 2:15 Three Concurrent Workshops  
Nutrition—Mrs. Robert E. Krone  
Membership and International Health—Mrs. Daniel S. Wolff and Mrs. Howard E. Smith  
Safety—Mrs. Donald Dewald
- 3:15 Coke Time and Adjournment

There will be no special guest speakers at this year's workshops. The general feeling among the county auxiliaries seems to be that they would prefer more active participation in the Fall Conference themselves rather than having to listen to a lengthy talk on a given subject, expert as that talk may be. To that end, each workshop session will run longer than in the past—one hour. And a good portion of that hour will be devoted to what everybody seems to want—time for plenty of questions and answers!

Since there will be four regional workshops, there must be four regional chairmen to handle the necessary details (including reservations) on

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## THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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|  |   |   |
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| <i>President</i><br>Mrs. Karl Ulicny<br>864 Highland Ave.<br>Salem, 44460            | <i>First Vice-President</i><br>Mrs. Howard E. Smith<br>2144 Fordway Dr.<br>Toledo, 43606  | <i>Recording Secretary</i><br>Mrs. Paul Cherenka<br>22425 Westchester Rd.<br>Cleveland, 44122   |
| <i>President-Elect</i><br>Mrs. S. J. Glueck<br>3405 Kappel Dr.<br>Springfield, 45503 | <i>Second Vice-President</i><br>Mrs. Henry Holden<br>2459 Fifth Ave.<br>Youngstown, 44505 | <i>Corresponding Secretary</i><br>Mrs. Carl F. Goll<br>1001 Granard Pkwy<br>Steubenville, 43952 |
| <i>Past President</i><br>Mrs. Louis Loria<br>Box 331, R.D. 1<br>Bristolville, 44402  | <i>Third Vice-President</i><br>Mrs. Albert May<br>655 Fairhaven Ave.<br>Marion, 43302     | <i>Treasurer</i><br>Mrs. William Myers<br>560 Lawnwood Ct.<br>Circleville, 43113                |





# Placidyl® (ETHCHLORVYNOL) Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated for short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and third trimester of pregnancy. Caution patients with possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in impairment of vision, paralysis of accommodation and loss of hypnosis. Caution patients concerning the use of a motor vehicle, operating machinery, or hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING LARGE DOSES AS LOW AS 1000 MG PER DAY FOR A PERIOD OF TIME WHEN THE DRUG WAS ABRUPTLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of withdrawal or symptoms which may indicate possible withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuance of the drug. Drug dosage should be limited in elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients do not respond unpredictably to barbiturates or alcohol who exhibit excitement and release of inhibition in association with such agents, may also respond in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, and muscular weakness, excitement, hysteria, and incoherence without marked hypotension. Transient dizziness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, drowsiness, facial numbness, and allergic reaction manifested by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 306433

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the local level. At the Dayton session, Mrs. S. J. Glueck is the one charged with that responsibility. At Findlay, it's Mrs. John Emery; at Youngstown, Mrs. Karl Wieneke; at Cambridge, Mrs. David Creamer.

It is fervently hoped that the counties will take advantage of this year's setup and urge their membership to attend what promises to be a lively, meaningful and helpful exchange of ideas, experiences and problems, along with some down-to-earth suggestions to make the auxiliary the super helping hand to the medical profession it truly wants to be!

I would like to point out to the county auxiliaries that your State Officers and Chairmen are really taking unto themselves a pretty heavy schedule (to say nothing of "heavy" driving) to reach you and help you in any way they can. So please—come to the Fall Conference in your area. It really will be worth your effort—it will be a learning day and a fun day!

### A Beautiful Prayer

The talented Mrs. S. B. Pfahl, state legislation chairman, wrote a beautiful prayer for the invocation at the state convention luncheon this past May. Because of convention and other special copy in recent months for this column, I did not have the space to include it before now. I feel it is too good not to share with the readers of this column, and so here it is—certainly never too late for any occasion!

"O Lord, we find it difficult sometimes to reach out and just touch another—yet we are not complete without you and the talents, interests, abilities and, yes, the inadequacies of each other. Let not one of us say we have no need for the other, but rather help us to combine our resources with those ideas that are just waiting to be born in our own county auxiliaries to make all our planning and programming work towards improving the quality of life and, above all, further your great and glorious purpose.

"Surely that also means knowing we aren't complete without our brothers who are oppressed, sick, hungry, hurting, lonely and weak. Help us to reach out and touch them with your kind of compassion and understanding that they might feel the power of your love in us. O Lord, help us to not get too busy in organized causes that we miss the needs of those who are yet closest to us.

"We are grateful for the power of your love that out of happenstance could draw us here together and has nurtured new friendships and renewed old ones. Surely that is one of the eternal rewards of such a meeting as this, that makes the sacrifice of leaving our homes somehow worth it.

"We are grateful too for the speakers who have come to challenge us with their vision that will open new doors and help us 'see what isn't

and ask why not?'. Grant us the wisdom to know where you are counting on us to make a difference in your world. O Lord, we appreciate Eileen's kind, sensitive, dedicated and often witty leadership of this past year and we ask your blessing on Susie as she begins a challenging and rather awesome responsibility. May she feel the strength of our support in the coming year.

"And one thing more, Lord. You know we have had fun here together and how much we can deeply care. Help us to reach out with that kind of caring to those who are saying to us—help—for if we do, we'll surely touch a star and You."

### Those Yearbooks

They're beginning to reach me—the 1973-74 yearbooks of the county auxiliaries and those I have received so far show some very fine programming and meaningful activity. It is a real education to leaf through these booklets and see what is going to happen at the grass roots level. Which is, of course, the auxiliary's foundation. May I remind those of you who have not yet sent me your yearbook to do so?

I'm also most interested in your newsletters. They are a wonderful source of material for this column. So please—keep 'em coming. . . . My congratulations to the writers of the newsletters. They are interesting and chatty and lively and, most important of all, graphic in their presentation of auxiliary and personal activity.

### Coming Up

The **Butler County** group will open the season with a bang—or perhaps I should say with a "pop"—a Champagne Brunch on September 25 at the home of Dr. and Mrs. Brady Randolph in Hamilton. Mrs. Karl Ulicny, state president, will be the honored guest. Guest speaker will be Mrs. Venita Kelly, a well-known Cincinnati fashion coordinator. (In reporting this and the following Lucas County items, please bear in mind that this is being written early in September for the *Journal's* October issue. It's a bit difficult to keep up with the times—auxiliary times that is—and be exactly on time!)

The first fall luncheon and general meeting of the **Lucas County** auxiliary will be held on October 9. Mrs. Richard M. Inglis, program committee chairman, and her cochairman, Mrs. Daniel R. Sullivan (along with an energetic committee) have put together a very timely and provocative program based on the theme "The Whole Woman." Mrs. William Eggleston, study group chairman, has worked hard and creatively to continue the famous Lucas auxiliary study groups which have been so successful in the past. She is also exploring the possibilities for potential new ones.

Study group offerings for the 1973-74 year include: Antiques and Art Glass; Art Classes;



Ballroom Dancing; Book Beat; Beauty Through Ballet; Bridge; Sewing; Swimming and Exercise; Tennis Clinic.

Since June, July and August are essentially vacation months with little or no auxiliary activity (other than those concerned with the year's program and the yearbooks and the newsletters and the planning—usually the joint project of the president, president-elect, and executive Board—), I am somewhat undernourished where local auxiliary happenings are concerned! Come to think of it, I can report that my own Scioto County group is having a salad smorgasbord on September 12 at the home of Dr. and Mrs. Richard Villarreal. Susie Ulicny, state president, will be our guest. Harry Schwartz' *The Case For American Medicine* will be discussed by Dr. Marie Rogowski.

### "Direct Line"

This is the very good newsletter from National sent out four times a year to all national, state and county officers and chairmen. In its most recent issue, there is a special message from Mrs. Willard C. Scrivner, president. She says: "Few discoveries will equal or benefit mankind more than the wheel. Yet, it is human to enjoy its benefits while too often giving little thought to its existence—to say nothing of appreciating its component parts.

"The hub of our organization structure is the county auxiliary with connecting spokes of state auxiliaries to our national rim binding all together. It is obvious that the hub must be strong to start the spokes toward their union with the rim, and without these interdependent parts, there would be no wheel.

"When friction exists in the hub, greater effort is required to overcome inertia, when spokes are split or missing, the whole rim's integrity is threatened and the workload may be impaired. In essence, the road of progress for our organization's projects and programs is best travelled with a wheel having strong hub supported by sturdy spokes banded together by a firm, durable rim capable of successful encounter with elements of the road of progress.

"Or, saying it another way—Through unity we become strong—Through Strength we become effective—We can and must be united—We can and must be strong through growing. We can and must be effective in our community leadership by being interested, informed and involved. Let us not dissipate our energies in trying to invent the wheel, but combine our efforts to push the wheel along its forward direction.

"To some, at first this might appear to represent a circle with haphazard markings, but to all, we hope it represents the working wheel of fiscal accountability."

Rather good food for thought, wouldn't you say?

## Colleagues Will Honor Columbus Surgeon

Friday and Saturday, October 19 and 20 have been designated as a period during which colleagues in medicine and surgery will honor Dr. Robert M. Zollinger, eminent head of surgery at Ohio State University College of Medicine for many years. Dr. Zollinger has retired as chairman of the Department of Surgery, but is continuing as a member of the faculty and is continuing his private practice.



Robert M. Zollinger, M.D.

The occasion will be marked by scientific programs Friday and Saturday in the Center for Tomorrow, 2400 Olentangy River Road, Columbus. Outstanding clinicians in medicine and surgery will participate in these programs to which all physicians as well as alumni of the College of Medicine are invited.

Highlight of the celebration will be a banquet on Friday evening, place of which is to be announced. Spearheading the celebration on behalf of the College of Medicine is the Zollinger Club, a group composed of former Zollinger students and colleagues.

To be presented at the banquet will be a portrait of the Big Z painted by the well-known artist Phillip Wilson.

The Zollinger Club was started in 1955, largely the brainchild of Dr. Edwin H. Ellison, former colleague and codeveloper of the Zollinger-Ellison Syndrome. Dr. Ellison died in 1970 while head of surgery at Marquette University School of Medicine. Dr. William G. Pace, assistant dean of the OSU College of Medicine, is secretary of the club.

Dr. Zollinger has been honored numerous times. He is one of the few physicians who have been president of the American College of Surgeons, president of the American Surgical Association, and chairman of the American Board of Surgery. He also is associated with numerous other professional organizations, is internationally known as a lecturer and author of numerous papers on surgical subjects.

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**For the treatment of impotence due to androgenic deficiency in the male.**

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of cli-

matic, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be dis-

continued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. In bottles of 60, 250.

Write for Literature and Samples **BROWN** THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th St., Los Angeles, CA 90057



480 Drugs May Be Removed from Market

The Food and Drug Administration has classified 480 drugs as "possibly effective" and they may be removed from the market and from use for your patients early in 1974 if their classifications have not been changed to "effective." The FDA has agreed to listen to the clinical experience of privately practicing physicians before banning those drugs.

The Ohio State Medical Association Committee on Private Practice urges you to complete and mail to the Committee, care of Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio, 43215, the following questionnaire. This will enable you and the Committee to contribute to a national physician survey of medical experience with 25 of the 480 drugs FDA is challenging.

- 1. Which of the following drugs have you used in the past six months?
- 2. Have you found the drug effective?

| Cough and Cold Drugs               | Used in past 6 months?                            | Found Effective?   | Oral Cardiovascular Drugs      | Used in past 6 months?                            | Found Effective?   |
|------------------------------------|---|--|--------------------------------|---|--|
|                                    | Yes No  | Yes No No opinion  |                                | Yes No  | Yes No No opinion  |
| Actifed C-Expectorant, BW          | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Cyclospasmol Tab. Cap. Ives    | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Ambenyl Expectorant, Parke Davis   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Duotrate 45 SRC, Marion        | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Benylin Expectorant, Parke Davis   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Peritrate Tab. Warner Chilcott | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Dimetapp SRT, Robins               | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Vasodilan Tab. Mead Johnson    | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Ornade SRC, SKF                    | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |                                |   |  |
| Phenergan Exp. with Codeine, Wyeth | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |                                |   |  |
| Tuss-Ornade Liquid, SKF            | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |                                |   |  |

If all combination cough and cold drugs were removed from the market, would it cause problems in your ability to care for your patients? ☐ Yes ☐ No

| Oral Skeletal Muscle Relaxant Drugs | Used in past 6 months?                            | Found Effective?   | Oral Antispasmodic and Anticholinergic Drugs | Used in past 6 months?                            | Found Effective?   |
|-------------------------------------|---|--|--|---|--|
|                                     | Yes No  | Yes No No opinion  |  | Yes No  | Yes No No opinion  |
| Equagesic Tab. Wyeth                | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Bentyl with Phenobarb Cap, Syr, SRT, Merrell | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Parafon Tab, McNeil                 | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Combid SRC, SKF                              | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Robaxin Tab, Robins                 | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Pathibamate Tab, Lederle                     | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
|                                     |   |  | Pro-Banthine/ Phenobarb Tab, Searle          | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

If all oral skeletal muscle relaxant drugs were removed from the market, would it cause problems in your ability to care for your patients? ☐ Yes ☐ No

| Topical Corticoid with Anti-Infective Ointments and Creams | Used in past 6 months?                            | Found Effective?   | Oral Proteolytic Enzymes | Used in past 6 months?                            | Found Effective?   |
|--|---|--|--------------------------|---|--|
|  | Yes No  | Yes No No opinion  |                          | Yes No  | Yes No No opinion  |
| Cortisporin Ont, Crm, BW                                   | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Ananase Tab. Rorer       | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Mycolog Ont, Squibb  | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Chymoral Tab, Armour     | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Neodecadron Crm, MSD                                       | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Orenzyme Tab, Merrell    | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Vioform HC, Crm, Ont, CIBA                                 | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |                          |   |  |

If all topical corticoid with anti-infective ointments and creams were removed from the market, would it cause problems in your ability to care for your patients? ☐ Yes ☐ No

|  |  |
|--|--|
| Has the Food and Drug Administration ever asked your opinion on any of these drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No         | What is your age? _____ <input type="checkbox"/> Male <input type="checkbox"/> Female  |
| Do you, as a rule, find combination drugs safe, useful, and effective? <input type="checkbox"/> Yes <input type="checkbox"/> No                      | Board Certified _____ ? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Do you, as a rule, find sustained release capsules and tablets safe, useful, and effective? <input type="checkbox"/> Yes <input type="checkbox"/> No | Type of Practice: <input type="checkbox"/> GP <input type="checkbox"/> IM <input type="checkbox"/> OB GYN <input type="checkbox"/> PED <input type="checkbox"/> UROLOGY <input type="checkbox"/> ALLERGY <input type="checkbox"/> DERM <input type="checkbox"/> DO |
|  | 039 If not one of the above, fill in type _____  |

Cap= Capsule, Tab=Tablet, Syr=Syrup, SRT=Sustained Release Tablet, SRC=Sustained Release Capsule, BW=Burroughs Wellcome, SKF=Smith Kline & French, MSD=Merck Sharp Dohme

# Change the AMA!

Maybe you're one of those doctors at odds with some AMA policies. Your question is: how do you change them?

First, consider who sets those policies. In a real sense, it is you. You elect the delegates to your state association. They in turn elect the delegates who will represent your views in the AMA House.

As an active, involved member, you can influence policy by making your views known to your delegates, both national and state. It is your democratic right — and responsibility.

Write your delegates, call them, see them. If they aren't responsive, tell them they'll be hearing from you at election time.

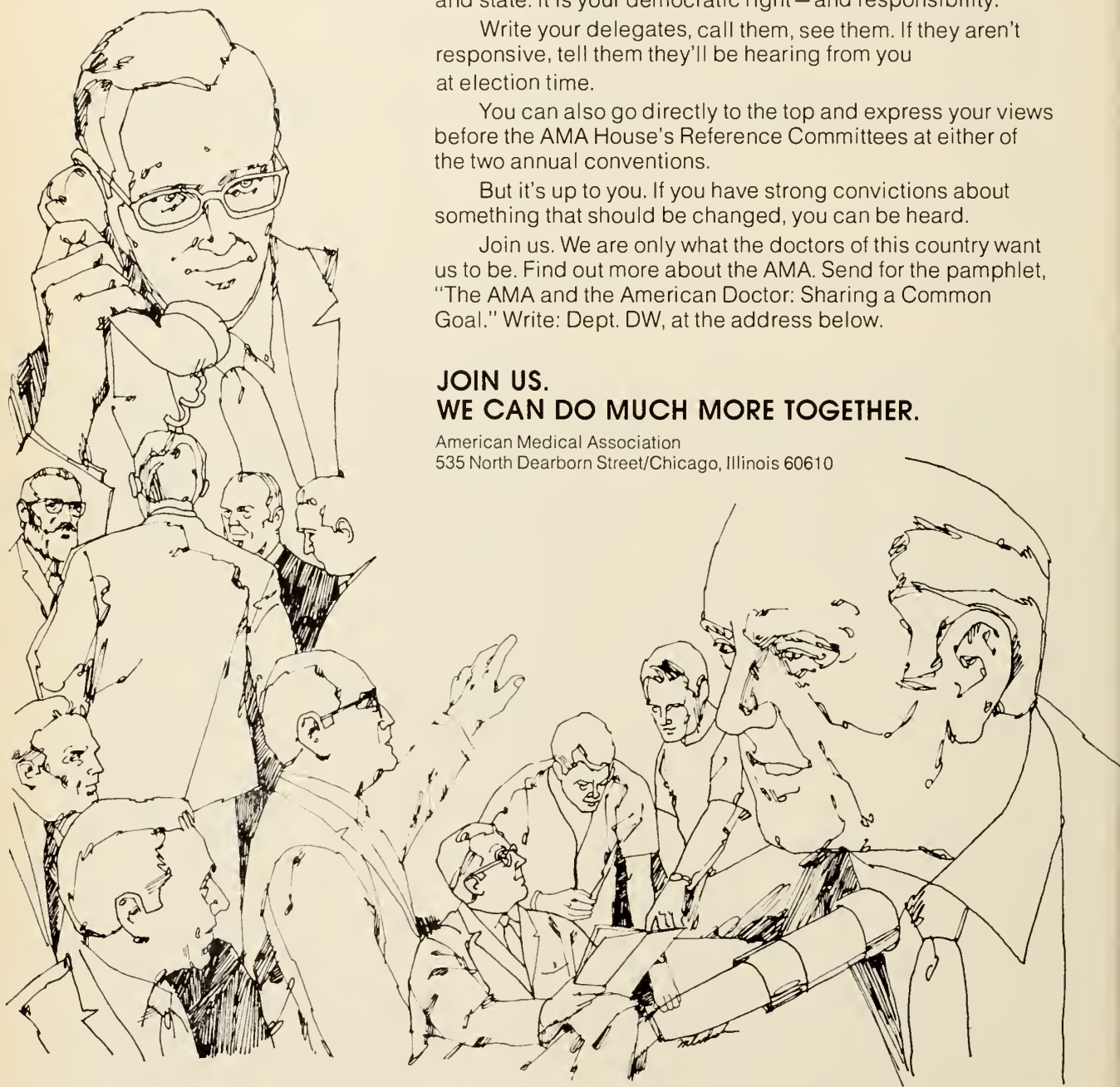
You can also go directly to the top and express your views before the AMA House's Reference Committees at either of the two annual conventions.

But it's up to you. If you have strong convictions about something that should be changed, you can be heard.

Join us. We are only what the doctors of this country want us to be. Find out more about the AMA. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

## **JOIN US. WE CAN DO MUCH MORE TOGETHER.**

American Medical Association  
535 North Dearborn Street/Chicago, Illinois 60610





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Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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**OHIO, FAIRFIELD.** Space available in modern Medical Building, 15 miles from Cincinnati. General Practitioner and Specialist needed. Reply to Box 616, c/o The Ohio State Medical Journal.

**PHYSICIAN'S OFFICE FOR RENT** in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio, Phone 271-0291.

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**EMERGENCY ROOM PHYSICIAN NEEDED IMMEDIATELY**—Established group of two full time and six part time physicians need third full time man for active emergency service. Incorporated. Salary \$36,000 to \$45,000 for 40-50 hours per week, plus bonus quarterly. Excellent 300 bed general hospital in community of 45,000 only 40 miles from Columbus. Many fine specialists available for help and referral. Please contact: L. H. Miller, M.D. 614-344-0331, Newark, O.

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(Continued from Previous Page)

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**FOR RENT OR SALE**: College Hill section of Cincinnati. Brick house suitable for professional office. 750 square feet plus. A. D. Berenson, M.D., 972 Spruce-land Dr., Cincinnati, O. 45224. 513/322-2789.

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**OFFICE FOR RENT**: For physician or dentist, 5 rooms, two lavatories, air-conditioned, free parking for patients, main floor, bus stop, 5 doctors medical building. Rent \$120. 19451 Euclid Ave., Euclid, O. 44117. Phone: 216/481-3058 or 216/371-4168. For dentist, medical patients addresses are available.

**MODEL RAILROAD 1/4" SCALE 2 RAIL D. C. CURRENT**. Superdetailed — locos and cars. 6 steam locos, 3 diesel and 1 gas-electric. 108 cars — passenger & all types freight. Locos with interior detail, engineer & fireman. All passenger, cabooses, work cars and unique 3 horse cars superdetailed with finished interiors, lighting & people. Road name of railroad Pine River & Northern. 3 D.C. Transformers, buildings, turntable, many parts. Many of the cars handcrafted to period 1880 to 1930 providing both hobby interest and collector value. Value a full \$5,000 — will sell \$4,000 cash. Reason — age 72. Marshall R. Rust — 207 Washington, Marietta, Ohio — phone 614-373-5247.

**FOR RENT OR LEASE: TOLEDO, OHIO**—East side; sole General Practitioner's office for 33 years, vacant by recent death; immediate income available; 8 room suite including 3 examining room; fully equipped x-ray and laboratory; central air-conditioning; carpeted; wood paneling; parking; nearby hospital. Suitable for one or two physicians; 2 air-conditioned apartments available in same building. Lease with option to buy equipment. Phone 419/691-6275 or reply Box 691, c/o Ohio State Medical Journal.

**OB-GYN BOARD CERTIFIED OR ELIGIBLE** to join solo incorporated Ob-Gyn in West Central Ohio. Equal share of net and equal time off from 1st day, plus liberal fringe benefits. Reply box 688 c/o Ohio State Medical Journal.

**LOCUM TENENS** — Ob-Gyn wanted for solo Ob-Gyn practice in Ohio first 3 weeks of November, 1973. \$1000.00 per week plus living expenses. Possible future association if desired. 12-15 OB's per month. Reply Box 687 c/o Ohio State Medical Journal.

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**OFFICE SPACE TO SHARE**: Cincinnati. Excellent location, close to main hospitals. Good maintenance and parking. Available now. Reply to box 690 c/o Ohio State Medical Journal or call 513/961-3240 or 821-2970.

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Page 1

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| NAME   | ADDRESS   |  |
| <b>Ohio State Medical Association</b>  | <b>17 S. High St., Suite 500, Columbus, Ohio 43215</b>  |  |
| A non-profit corporation with no stock outstanding.  |   |  |
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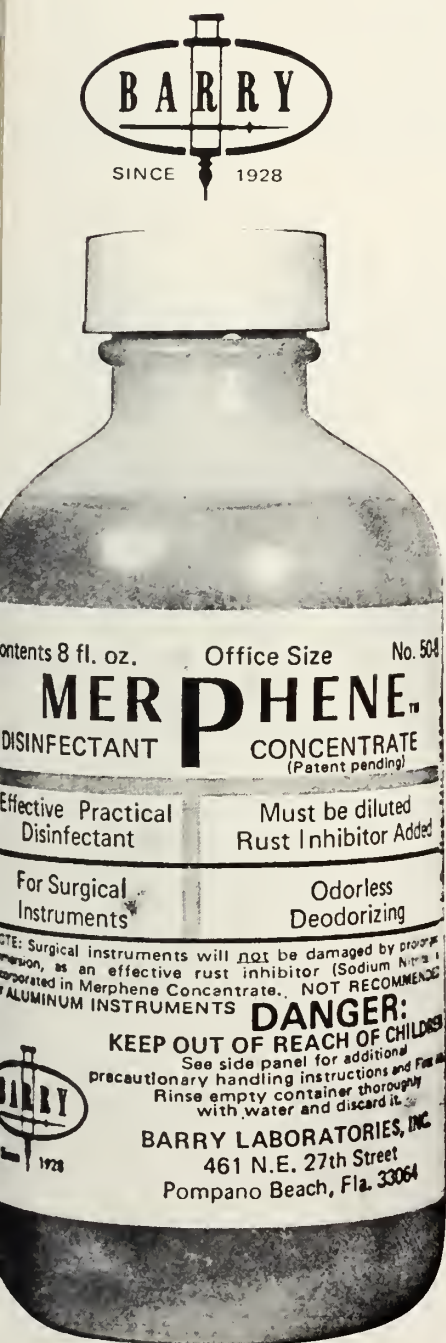
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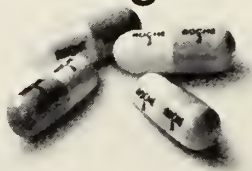
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**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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NOVEMBER • 1973  
VOL. 69 NO. 11

# *The Ohio State* MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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50 NOV 1973

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**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

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## The Ohio State MEDICAL JOURNAL

VOL. 69 NOVEMBER, 1973 No. 11

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# Medical Care

By OSCAR W. CLARKE, M.D., Gallipolis  
President, Ohio State Medical Association

**P**ROBLEMS in medical and health care delivery include: (1) Quality of medical care; (2) Rising health care cost; (3) Equal access to care; and (4) Problems of maldistribution of providers of care.

Quality must be the essential element in whatever we do to broaden the delivery of care and broaden it, we must!

Many of the proposals before us for delivery of care have the major thrust of **quantity of services**, the masses rather than the individual, with the hope the **quality** will follow naturally.

There is no provision in these proposals for the essential bond between the patient and the physician, nor time for understanding the patient as an individual and as a whole person, nor time to administer to his fears as well as his illness. All of the impersonal clinical skills available will not satisfy his needs.

Dr. Carl Hoffman, Past President of the American Medical Association, stated last June that he had observed a paradox in regard to quality—and I might state that the same observation has occurred to many of us.

It should be well known that the quality of medical care can be no better than the education upon which it is founded. Now we observe the following paradox.

## Hasty Education

There is a great push, and need for continuing education for the practicing physicians, and the allied professionals. However, we have set up and condoned a reduced hurried curriculum for the student in medical school and allied professional schools.

Dr. Hoffman has asked the following questions:

Why—when the sheer volume of knowledge to be absorbed is greater than before?

Why—when the true need of our profession is to produce not narrowly trained super specialists, but human physicians who understand and relate to people?

Why—when the most important single quality in a physician is maturity of judgment? Maturity is a quality that develops out of time and experience. It can hardly develop within the context of a speed-up.

The only answer available is the physician “shortage.”

Is this the true answer? Will it really meet and satisfy our needs?

I think not. I believe there is a great need for a “whole physician”—not a narrowly trained scientist at this time, and the abolition of the rotating internship is a mistake. I believe it should be reestablished and particularly in approved community hospitals.

## Need vs. Demand

Many have studied the questions of medical **need** and medical **demand**, and it is well known that we will never satisfy the medical **demand**. We must address ourselves to the medical **need**.

The simple fact of producing rapidly a large number of physicians in a given time will not meet our **need**, and certainly not satisfy the **demand**.

This leads us into the often stated hoax: Increase the number of physicians and we will solve the problem of access to medical care.

The simple increase in numbers will not solve the maldistribution problem.

This problem is with us in spite of our national ratio of 133 direct-care physicians per 100,000 population—one of the highest in the world and one that keeps improving each year. June, 1972, medical schools graduated almost 10,000 doctors—twice the number at the end of World War II.

Those of you who are familiar with the worldwide picture know this problem is not unique to the United States—the highly nationalized and regulated medical systems face this problem continually.

The problem divides itself into two parts—the kind of physician we train and where he chooses to practice.

Approaching the **KIND** of physician problem, should we limit the specialty training residencies and increase the primary physician residencies? Some would say this is the answer. It would require unheard-of cooperation among the special

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This article is based on the text of an address given by Dr. Clarke on September 12 before the 54th Annual Ohio Health Commissioners Conference in Columbus.

interest groups. Who would decide where to cut back, and whom to cut back? Could it be done by reassessment of our priorities for capitation grants, giving the larger award for the primary type training.

Again, simply producing the primary care physicians is not going to produce a balanced geographical distribution.

Practice in the understaffed rural areas and inner city involves cultured bias, family preferences, economics, psychological forces and many other intangibles.

The young doctor today prefers the urban environment. There is no joy to be seen in extra long hours, the lack of sophisticated facilities and postgraduate education. These factors certainly discourage the young physician and, I might add, the young of the other highly trained professionals—lawyers, bankers, architects, and skilled craftsmen.

### An Intelligent Experiment

I certainly have no sure prescription for this problem. However, there are developing certain incentives. One, for example, is the National Health Service Corporation—not that this is a howling success. However, it is an intelligent experiment—and I feel it could be expanded and broadened.

There are other incentives being tried, such as forgiveness of student loans, tuition payments, practice grants, tax exemptions, and community provision of free office and equipment facilities.

Some have tried actually going into these areas to recruit the medical student in the hope that he or she will return to the area.

I feel that the establishment of facilities for group practices with easy communication to a larger medical facility would be most encouraging in inducing the young professional to locate in the rural and inner city areas.

I feel, as Dr. Malcolm Todd, AMA President-Elect, stated in *Medical Opinion* last spring, "Medical schools that glorify research and technology at the expense of training doctors to provide patient care are failing, to a degree, the society that supports them as well as influencing decisions that should be made with both sides fairly presented. If bias there be, it should be on the side of producing physicians to take care of **patients**. It is the patient who in actuality pays the tuitions and the hospital bills one way or the other."

### Lesson in Supply/Demand

Rising health care cost is a demon with many heads being fed by many factors. Probably the foremost factor was the sudden demand for ser-

vices created by government programs without proper planning. It is a simple lesson in economics that cost will spiral when the demand exceeds the supply.

I lay this head of the dragon at the feet of those who used medicine as a political issue and damn the doctors, damn the hospital administrators and double damn over-utilization by the patient. In spite of this, the politicians who used medicine as an emotional issue to further their own ambitions created this demon and they cannot duck it. Unrealistic promises were made by those who did not have to produce, and they are now shocked to reap the problems.

Couple unprecedented demand with an economy that was rising into the present swirl of inflation and you have another head of the demon.

Those of you who are familiar with hospital administrative history are aware of the sudden revolution forced upon hospitals in regard to updating a historically low employee pay scale to presently acceptable levels. Labor cost still consumes the greatest part of the hospital dollar.

As if this were not enough, add on the terrific advances in medical sophistication with the demand for unheard-of expensive equipment and facilities.

After consideration of the above facts, one should not be mystified by the cost of the hospital portion of medical care.

I don't wish to paint the medical profession as absolutely lily white in the cost spiral. However, I feel that a comparison of professional medical fees with the remainder of the economy, including T.V. repair, auto repair, plumbing costs and labor charges, we have a good record. In fact, since professional fees have been placed under a price ceiling, we physicians have not actually reached the allowed ceilings nationally.

There are those who, upon consideration of the problems presented in this paper, would immediately abandon the American systems of individual doctor-patient relationship and institute health systems developed in the more socialistic countries. There are those who would say we can cure all of the ills by establishing a health maintenance organization which, upon close examination, has as its big feature, contract practice.

They say, "If only we could establish a pre-paid system, we could cure all the ills of hospital cost, over utilization, and provide for the patient a system of care which would prevent many of the present shortcomings and abuses of the present delivery of care."

I for one feel that this **experiment** should be made. I feel that we should have the knowledge of how medical care delivered to a full spectrum sample of the people would function. I feel that it should cover the whole patient pattern, not just



the selected working age group. I feel it should be subsidized to any degree exceeding the present system in order to get a **true** picture for comparison. However, those of you who followed the HMO Legislative proposals did note that, in the Senate version, huge sums were earmarked to provide free subscription to the HMO plan for large numbers—in addition to subsidizing the actual establishment of the HMO structure itself.

It reminded me of a New York theatrical producer approaching a financial backer with the request for \$100,000, stipulating that \$50,000 would go for ticket purchases for the public in order to assure a success!

I, personally, have fears that, in the rush and haste to meet a politically inspired medical crisis, we may destroy one of the most—if not the most—worthwhile systems of medical care in the world.

In closing, I would like to recognize a statement made to the AMA House of Delegates in

New York City on June 27, 1973 by Dr. Charles C. Edwards, assistant secretary for Health, Education and Welfare, and I quote:

“The medical profession and other elements of the private health sector can choose either of two routes. They can choose to minimize the role of the Federal Government because they regard government involvement as a threat to professional and institutional freedom. Or they can view government and private interest as interdependent participants whose appropriate balance is critical if we are to meet the health needs of the people of this country.”

I would like to answer Dr. Edwards in regard to the federal role:

“Dr. Edwards, we shall accept appropriate balance until it threatens our professional and institutional freedom and, should that occur, we of organized medicine shall resist you to the last man.”

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## Continuing Education Opportunities for Physicians in Ohio

### November

**Occupational Medicine and Environmental Health**—2-week full-time course with emphasis on clinical and environmental hygiene problems, coverage of OSHA; November 5 to November 16; tuition \$600; for details contact Sidney Lerner, M.D., Kettering Laboratory, Department of Environmental Health, College of Medicine, University of Cincinnati, Cincinnati, Ohio 45219.

**Toxemia of Pregnancy**—Educational Forum sponsored by the Cleveland Society of Obstetricians and Gynecologists, at the Marriott Inn, 4277 W. 150th Street, Cleveland, November 14, beginning at 3:00 p.m.; guest speaker, Russell DeAlvarez, M.D., Temple University; dinner and evening meeting, 7:00 p.m. with Dr. DeAlvarez continuing the discussion on the same subject. Contact Lester A. Ballard, Jr., M.D., Secretary, Clinic Center, 9500 Euclid Avenue, Cleveland 44106.

**Biomechanics** — Sponsored by American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago 60611; at Case Western Reserve University School of Medicine, November 5-9.

University of Cincinnati College of Medicine (CONMED):

**Ophthalmologist for the Generalist** — November 8 at the Shrine Burns Institute.

**Basic Principles of Rhinoplasty** — November 11-14, cosponsored by the American Academy of Facial Plastic and Reconstructive Surgery and the UC Dept. of Otolaryngology and Maxillofacial Surgery.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

**Multiple Drug Dependency—Diagnosis and Management**—Symposium sponsored by the Ohio State Medical Association and a number of other professional organizations, at the Imperial House North, Morse Road at I-71, Columbus, November 8. Contact OSMA at 17 South High Street, Columbus 43215; phone 614/228-6971.

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

**Industrial Audiometry and Conservation of Hearing** — November 7-9; at Stouffer's University Inn, 3025 Olentangy River Rd., Columbus.

**Vascular Disease** — at Stouffer's University Inn, 3025 Olentangy River Rd., Columbus; November 9-10.

**Pathophysiology of Trauma** — Sponsored by the American Academy of Orthopaedic Surgeons, at OSU, November 14-16.

(Continued on Page 806)



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# Educational Opportunities in Ohio — *Continued*

## November (Contd.)

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:

Gastroenterology — November 14-15.

Akron City Hospital, Market & Arch Sts., Akron 44309:

Visiting Professor Program, Dept. of Surgery, November 8-9, Bruce G. MacMillan, M.D.

What the Medical Subspecialist Thinks the Primary Practitioner Should Know About His Field, Nov. 21.

Visiting Professor Program, Dept. of Pathology, Nov. 29-30, Stephen E. Ritzmann, M.D.

Why Should We Control Blood Sugar? — Youngstown Hospital Association, South Unit, Guest Professor, Manuel Tzagournis, M.D., assistant dean, OSU College of Medicine, Nov. 15, 8:00 a.m.

Courses Sponsored by Medical College of Ohio at Toledo; for details contact MCO Office of Continuing Education, P. O. Box 6190, Toledo 43614.

Acute Gastrointestinal Disorders During Pregnancy — Clinical Seminar on Emergency Medicine — November 8, at Holiday Inn, Defiance, 4:00 to 9:00 p.m.

The Multiple-Injury Patient — Clinical Seminar on Emergency Medicine — November 13, Providence Hospital, Sandusky, 4:00 to 9:00 p.m.

Water and Electrolyte Disturbances in Surgical Patients — Seminar on Fundamentals of Surgery — November 3 and 10, 10:00 a.m. to noon, Room G-1 at MCO.

Blood — Normal and Abnormal Coagulation — Seminar on Fundamentals of Surgery — November 17, 10:00 a.m. to noon, Room G-1 at MCO.

Symposium on Ulcerative Colitis — November 29 at MCO.

## December

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

Cardiology — December 3.

Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106.

Advances in Ophthalmology — December 5-6.

Workshop on Fluid and Electrolyte Clinical Problems — December 12 at Jewish Hospital, Cincinnati; and Urology X-ray Seminar — December 13-15 at the Netherland Hilton Hotel; University of Cincinnati College of Medicine (CONMED).

Medical Economics — Akron City Hospital, 525 E. Market St., Akron; December 19.

Akron City Hospital, Market & Arch Sts., Akron 44309:

Visiting Professor Program, Dept. of Ob-Gyn, John T. Queenan, M.D., December 5-6.

Medical Economics, December 19.

Courses Sponsored by Medical College of Ohio at Toledo; for details contact MCO Office of Continuing Education, P. O. Box 6190, Toledo 43614.

Acute Complications Related to The Pill — Clinical Seminar on Emergency Medicine — at Blanchard Valley Hospital, Findlay, December 6, 1:00 to 5:00 p.m.

Blood Volume: Maintenance/Replacement — Seminar on Fundamentals of Surgery — December 1, Room G-1 at MCO, 10:00 a.m. to noon.

Metabolic Responses to Surgery — Seminars on Fundamentals of Surgery — December 8 and 15, 10:00 a.m. to noon, Room G-1 at MCO.





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**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions.

The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonyleurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement. (B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
Division of CIBA-GEIGY Corporation  
Ardley, New York 10502



# More than sleep.

your choice of sleep medication  
is wisely based on more than  
sleep-inducing potential

## sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dalmane (flurazepam HCl); no depression of cardiac or respiratory function was noted in patients administered recommended or higher doses for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldom required discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. Drowsiness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hours  
without need to  
repeat dosage

No sleep medication has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia patients given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer nighttime awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to repeat dosage during the night.



Keep with  
consistency

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other sedative hypnotic.

When your evaluation of insomnia indicates the need for a sleep medication, consider Dalmane—a single entity nonnarcotic, non-habit-forming agent proved effective and relatively safe for relief of insomnia.

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

**DALMANE<sup>®</sup>**  
(flurazepam HCl)

**When restful sleep  
is indicated**

**One 30-mg capsule h.s. — usual adult dosage**  
(15 mg may suffice in some patients).

**One 15-mg capsule h.s. — initial dosage for elderly or debilitated patients.**

**Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:**

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



ROCHE LABORATORIES  
Div., Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110

# **It's time for action to defend the laws and regulations that protect your patients against drug substitution.**

**These professional and trade organizations are united in supporting antisubstitution statutes and regulations:**

The American Academy of Dermatology

The Board of Directors of the  
American Academy of Family  
Physicians

The Executive Board of the  
American Academy of Neurology

The Committee on Drugs of the  
American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the  
American College of Obstetricians  
and Gynecologists

The Board of Regents of the  
American College of Physicians

The Board of Trustees of the  
American Dental Association

The Board of Trustees of the  
American Medical Association

The American Psychiatric Association

The Executive Committee of the  
National Association of Retail  
Druggists

The Board of Directors of the  
Pharmaceutical Manufacturers  
Association

The National Wholesale Druggists'  
Association





## Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the best source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus maintained and preserved in the interest of patient welfare.

The antisubstitution laws have obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists of their responsibilities to patients. In practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug selection, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that

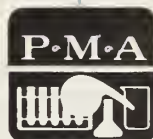
economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

*Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D. C. 20005*



ROCHE announces  
new

**BACTRIM<sup>TM</sup>**

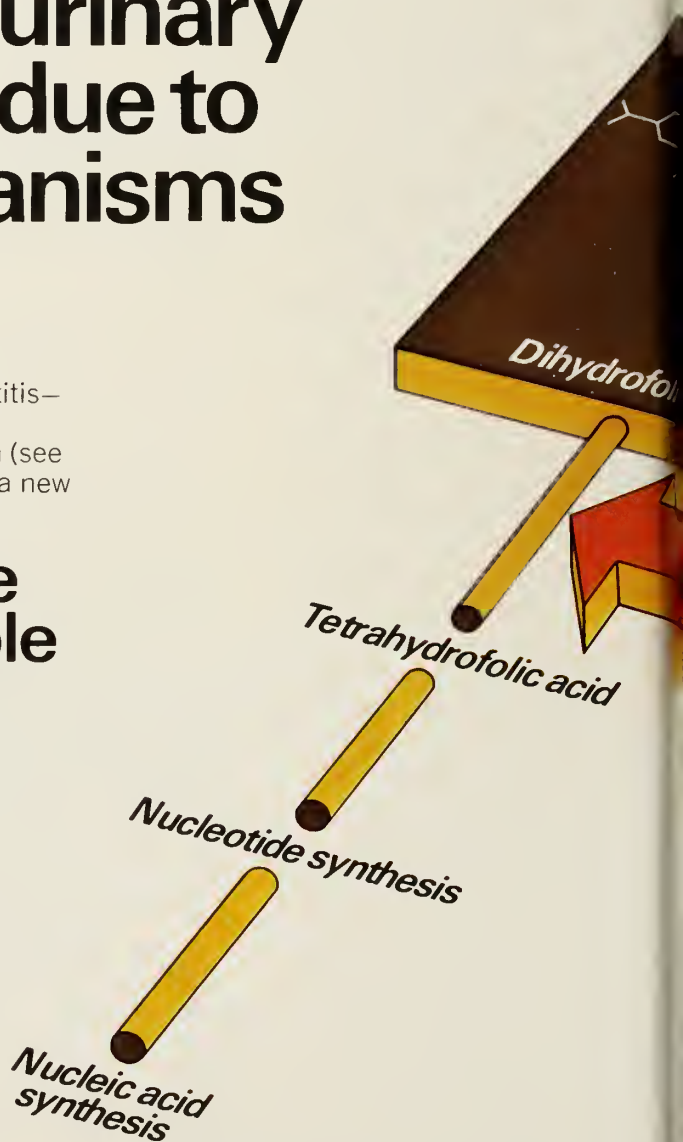
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

# a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

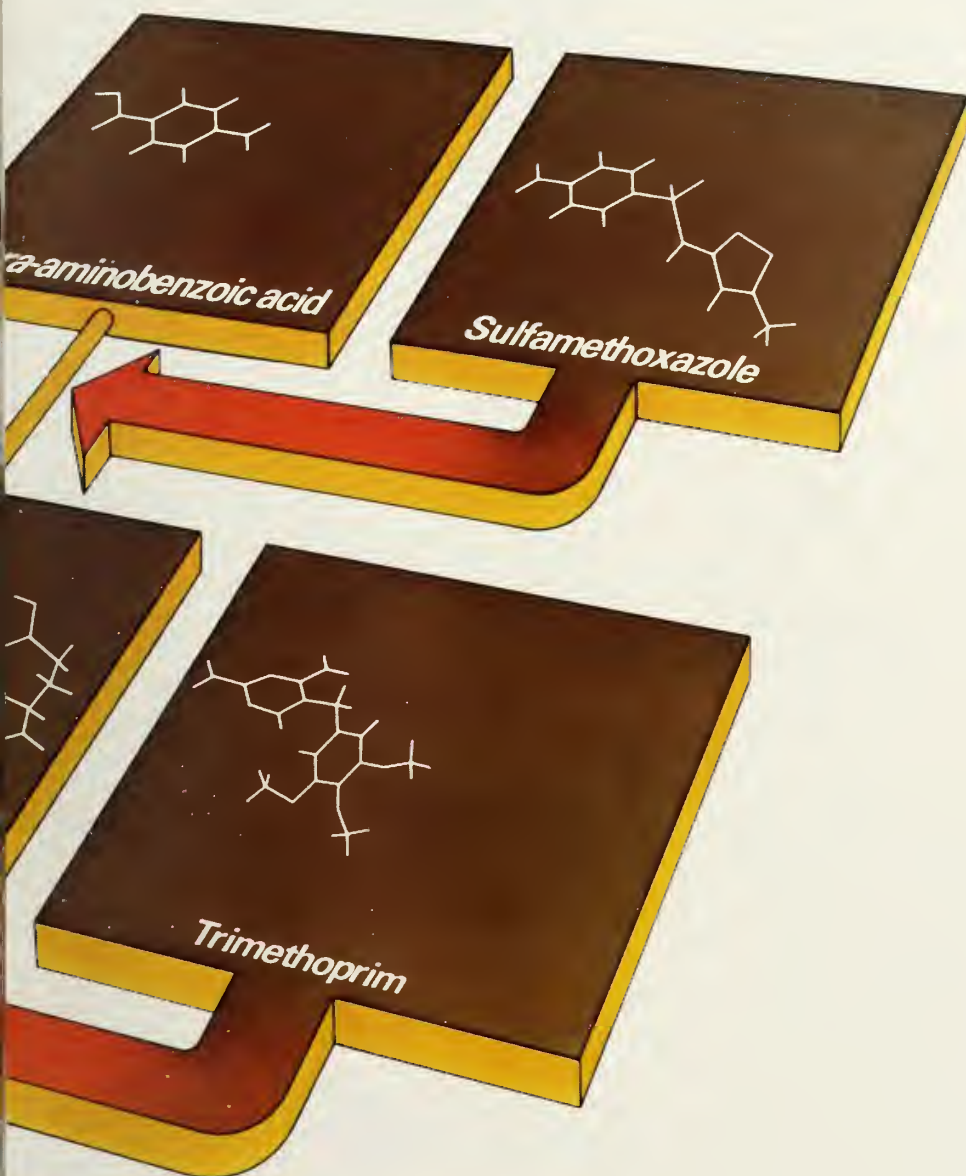
Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

## Bactrim interrupts the life cycle of susceptible bacteria

*Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.*







new **BACTRIM**<sup>TM</sup>

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**

Before prescribing, please see complete product information on last page of advertisement.

## Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study\* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

## Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

## Prescribing considerations

**Clinical Limitations:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

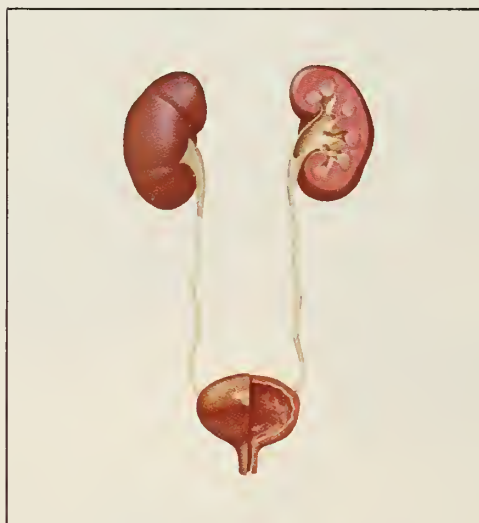
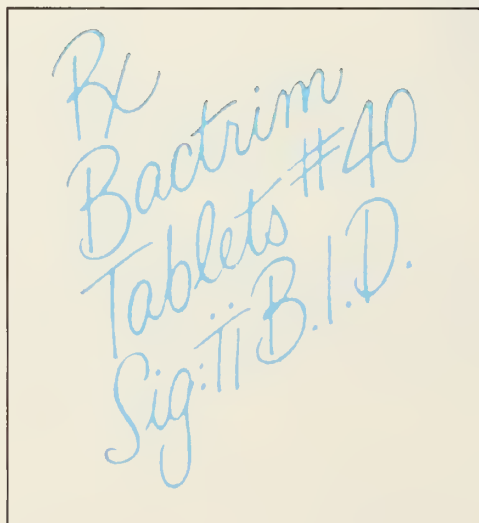
**Warnings and Precautions:** Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Effects:** Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

**Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.**

\*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

†4 patients not available for evaluation at day 10.



**new** **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

**for chronic urinary tract infections**



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.



Complete Product Information:

**Description:** Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N<sup>1</sup>-(5-methyl-3-isoxazolyl)sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

**Actions: Microbiology:** Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

*In vitro* studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

*In vitro* serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

| Representative Minimum Inhibitory Concentration Values<br>for Bactrim-Susceptible Organisms<br>(MIC—mcg/ml) |                       |                           |  |            |
|---|-----------------------|---------------------------|--|------------|
| Bacteria  | Trimethoprim<br>alone | Sulfamethoxazole<br>alone | TMP/SMX (1:20)<br>TMP                      SMX |            |
| <i>Escherichia coli</i>   | 0.05—1.5              | 1.0 —245                  | 0.05—0.5                                       | 0.95— 9.5  |
| <i>Proteus</i> spp.<br>indole positive  | 0.5 —5.0              | 7.35 —300                 | 0.05—1.5                                       | 0.95—28.5  |
| <i>Proteus mirabilis</i>  | 0.5 —1.5              | 7.35 — 30                 | 0.05—0.15                                      | 0.95— 2.85 |
| <i>Klebsiella-Enterobacter</i>  | 0.15—5.0              | 0.735—245                 | 0.05—1.5                                       | 0.95—28.5  |

**Human Pharmacology:** Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

**Indications:** Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

**Important note:** Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

**Warnings:** Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

**Precautions:** Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

**Adverse Reactions:** For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

**Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

**Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

**Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

**C.N.S. reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

**Miscellaneous reactions:** Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarthritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

**Dosage and Administration:** Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

| Creatinine Clearance<br>(ml/min) | Recommended Dosage<br>Regimen |
|----------------------------------|-------------------------------|
| Above 30                         | Usual standard regimen        |
| 15-30                            | 2 tablets every 24 hours      |
| Below 15                         | Use not recommended           |

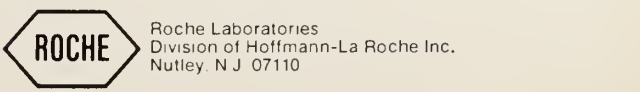
**How Supplied:** Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

**Reproduction Studies:** In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

**BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.





Following are names of new members of the Ohio State Medical Association certified to the headquarters office during September. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

#### BUTLER

Roberto S. Garcia-Rivera  
Hamilton  
E. Thomas Leyrer  
Hamilton

#### COLUMBIANA

Argon Mavi  
Salem

#### CUYAHOGA (Cleveland, except as noted)

Julio C. Airal  
Charles M. Bailin  
Florante A. Baldado  
Norberto M. Bangayan  
Glen S. Bartlett  
Renato M. Bosita  
Charles Coakwell III  
Delia M. Di Gregorio  
North Olmsted  
Kamal A. H.  
El-Hamshari  
Romeo C. Enrique  
Norman T. Gensolin  
Joon P. Hong  
Jorge T. Jandi  
Harold Kaiman  
Soo Ho Kim  
Paul S. Lavik  
William P. Mahoney, Jr.  
Thomas C. McLaughlin  
Josefina G. Morona  
Roberto V. Morona  
John R. Murphy  
Rodion Palazij  
Madhira D. Ram  
Kenneth G. Reeb  
Jacques F. Roux  
John B. Sawyer  
Lawrence J. Schreiber

Juliet L. So-Bosita  
Thomas J. Stefanik  
Brigitte N. Streeter  
Dominador A. Tolentino  
Nora L. Tolentino  
Lawrence W. White

#### HAMILTON (Cincinnati)

Anton L. Ambrose  
Thomas S. Berger  
Gerald A. Bouchard  
William J. Dalton  
William H. Egan  
Lawrence C. Freeman  
Lawrence A. Levine  
Gerald R. Reiter  
Arthur I. Richards  
Helmut F. Schellhas  
Sally L. Taylor

#### HANCOCK

Alberto G. Angustia  
Findlay

#### LICKING

Charles W. Kelly Parke  
Newark

#### LUCAS (Toledo, except as noted)

Maria Bailas  
Pooran C. Barman  
Su-Pa Kang  
Fidencio A. Trevino  
Willis J. Wendler, Jr.  
Perrysburg

#### MONTGOMERY

Edith R. McNutt  
Dayton

Dr. Stanley van den Noort has been named dean of the College of Medicine at the University of California, Irvine. Prior to joining UCI in 1970, he was on the faculty of Case Western Reserve University, Cleveland.

## Schools Enlisted for Study on Cholesterol-Triglycerides

The Princeton City School District, of Hamilton County, has been selected as part of a nationally supported program to measure blood lipids in public and parochial school students and their parents. The University of Cincinnati Medical Center is cooperating in the study.

Approximately 5,500 students in Grades 1, 3, 5, 7, 9, 11, and 12 this year were eligible to volunteer. Participation is entirely voluntary and without cost to students or parents.

Dr. Charles J. Glueck, UC associate professor of medicine, and Dr. Joseph L. Rauh, Princeton school physician, are heading up the medical aspects of the program.

Princeton School District is one of 12 communities in the nation selected to take part in the program to measure blood lipids. It is the only community in which school children of all ages are participating.

This program is a first step in the National Institutes of Health—National Heart and Lung Institute project designed to investigate the relationship of lipids to atherosclerosis and ultimately to develop methods of preventing coronary artery disease and other complications of atherosclerosis.

The Princeton program will provide a general model for feasibility of using public school screening as an improved method of early detection of diseases. In collaboration with other studies it should provide badly needed normal limits for cholesterol and triglyceride levels in normal school populations.

## Physicians for Vietnam Program Is Discontinued

The Volunteer Physicians for Vietnam program, which was initiated as "Project Vietnam" in 1965, has been terminated. The last physician volunteer departed from Vietnam prior to June 30, 1973 and the VPVN office in Saigon was closed in July.


The American Medical Association has been responsible for the administration of this program under a contract with the Agency for International Development (AID) since July 1966.

Under this program some 1029 American physicians participated, accepting one or more tour of service in Vietnam where they brought medical treatment to the civilian population. About 45 of these physicians were from Ohio.



# Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.



INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in:

- infected burns, skin grafts, surgical incisions, otitis externa
- primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia)
- secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis)
- traumatic lesions, inflamed or suppurating as a result of bacterial infection.

*Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

## NEOSPORIN<sup>®</sup> Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin<sup>®</sup> brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q.s. In tubes of 1 oz. and ½ oz. and ¼ oz. (approx.) foil packets.



Burroughs Wellcome Co.  
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## New Law Expands Policy on Burial of Veterans

A new National Cemetery System operating under the jurisdiction of the Veterans Administration is now in effect.

Donald E. Johnson, Administrator of Veterans Affairs, said that under a law signed by the President June 18, 1973, some 1,000 Department of Army employees and 82 national cemeteries operated by the Army were transferred to the VA on September 1, 1973.

On the same date, 21 VA cemeteries were converted into the new system as national cemeteries, thus making available an additional 53,680 VA grave sites for the burial of veterans who qualify as veterans under the law. Prior to September 1, VA cemeteries were generally limited to the burial of veterans who died in VA facilities.

Excluded from the new 103 VA cemetery system are Arlington National Cemetery, cemeteries at the three military service academies, the U.S. Soldiers and Airmen's Home Cemetery at Washington, D.C., and the U.S. Naval Home Cemetery in Philadelphia.

Also excluded are the U.S. military cemeteries in foreign countries, which are under the jurisdiction of the American Battle Monuments Commission.

Of the 103 cemeteries in the new system, 56 still have grave sites available. The 56 open cemeteries are located in 28 states and Puerto Rico.

In addition to creating the new National Cemetery System, the law increased burial benefits

for veterans. An additional \$150 plot allowance is authorized for veterans buried in private cemeteries after August 1, 1973, in addition to the \$250 burial allowance already authorized, and the payment of up to \$800 in funeral allowances is now available on behalf of veterans who die of service-connected causes.

## Artificial Thumb Implant Performed at Cincinnati Medical Center

The first implant of an artificial thumb joint in a human recipient was performed at the University of Cincinnati Medical Center on September 18 of this year, a spokesman for the center reported.

The joint, fashioned from a cobalt alloy, was developed by surgeons and biomedical engineers at the Biomechanics and Biomaterials Laboratory at U.C.

The operation was performed by a team of surgeons at Cincinnati General Hospital, major teaching hospital in the UC Medical Center.

The patient is a 54-year-old man who lost the use of his thumb as the result of an old injury which necessitated a surgical stiffening operation. The stiffening operation was the only method of treating the disorder prior to the development of the artificial joint. Preliminary evaluation indicated the implant was successful.



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# Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

## **VASODILAN<sup>®</sup>** (ISOXSUPRINE HCl)

**the compatible vasodilator...  
no treatment conflicts reported**

The cerebral or peripheral vascular disease patient often has coexisting disease<sup>1</sup> which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

**Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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734D17

1. Gertler, M. M., et al.: Geriatrics 25:134-148 (May) 1970.

**Mead Johnson** LABORATORIES

# REPORT ON EXAMINATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED DECEMBER 31, 1972

## ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations  
Ohio State Medical Association  
Columbus, Ohio

We have examined the balance sheet of Ohio State Medical Association at December 31, 1972 and the related statements of operations and net worth and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of Ohio State Medical Association at December 31, 1972 and the results of its operations and changes in financial position for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Columbus, Ohio  
June 11, 1973

*Coopers & Lybrand*

### OHIO STATE MEDICAL ASSOCIATION BALANCE SHEET, December 31, 1972

#### ASSETS

##### Current assets:

|   |                |
|---|----------------|
| Cash, including time deposits of \$47,031 .....                         | \$ 49,397      |
| 5¾% Certificate of deposit .....  | 20,000         |
| Accounts receivable, less allowance for doubtful accounts of \$20 ..... | 11,619         |
| Accrued interest receivable .....                                       | 343            |
| Prepaid expenses (including \$28,400 of unamortized pension costs) .... | 32,437         |
| Total current assets .....  | <u>113,796</u> |

##### Other assets:

##### Investments:

|  |                |
|--|----------------|
| General Trust Fund, at cost which approximates market .....      | \$ 17,845      |
| Ohio Medical Indemnity, Inc., at cost (Note 3) .....             | 56,000         |
| Deposits .....   | 544            |
| Unamortized pension costs, net of current portion (Note 2) ..... | <u>216,600</u> |
|  | 290,989        |

##### Property and equipment, at cost (Note 1):

|                                     |                  |
|-------------------------------------|------------------|
| Real estate .....                   | 182,200          |
| Furniture and fixtures .....        | 61,459           |
| Less accumulated depreciation ..... | <u>(31,823)</u>  |
|                                     | 211,836          |
|                                     | <u>\$616,621</u> |

#### LIABILITIES AND NET WORTH

##### Current liabilities:

|                                 |               |
|---------------------------------|---------------|
| Accounts payable .....          | \$ 31,711     |
| Deferred membership dues .....  | 41,220        |
| Other deferred income .....     | 7,613         |
| Total current liabilities ..... | <u>80,544</u> |

|                          |                  |
|--------------------------|------------------|
| Net worth (Note 5) ..... | 536,077          |
|                          | <u>\$616,621</u> |

(The accompanying notes are an integral part of the financial statements.)



OHIO STATE MEDICAL ASSOCIATION  
STATEMENT OF OPERATIONS AND NET WORTH  
for the year ended December 31, 1972

|  |           |                  |
|--|-----------|------------------|
| Income:  |           |                  |
| Membership dues .....  |           | \$615,750        |
| Exhibit fees .....   |           | 26,280           |
| Annual meeting .....   |           | 6,359            |
| Fees for collection of AMA dues .....                          |           | 7,818            |
| Interest on savings accounts and certificates of deposit ..... |           | 11,703           |
| General Trust income .....                                     |           | 7,211            |
| Other .....  |           | 6,749            |
|  |           | <u>681,870</u>   |
| Operating expenses:  |           |                  |
| Ohio State Medical Journal, net .....                          | \$ 68,092 |                  |
| Salaries .....   | 194,861   |                  |
| Honorariums and expenses .....                                 | 56,188    |                  |
| Professional conferences and scientific meetings .....         | 92,880    |                  |
| Committee expenses .....                                       | 31,090    |                  |
| Public relations .....   | 5,053     |                  |
| Employee benefits, including pension costs of \$28,400 .....   | 45,822    |                  |
| Contributions .....  | 16,818    |                  |
| General operating expenses .....                               | 122,579   |                  |
|  |           | <u>633,383</u>   |
| Net income from operations (Note 5) .....                      |           | 48,487           |
| Net worth, beginning of year .....                             |           | <u>487,590</u>   |
| Net worth, end of year .....                                   |           | <u>\$536,077</u> |

OHIO STATE MEDICAL ASSOCIATION  
STATEMENT OF CHANGES IN FINANCIAL POSITION  
for the year ended December 31, 1972

|  |           |                  |
|--|-----------|------------------|
| Source of funds:   |           |                  |
| From operations:   |           |                  |
| Net income .....   |           | \$ 48,487        |
| Depreciation and amortization not requiring working capital (including \$28,400 relating to pension costs) ..... |           | 33,620           |
|  |           | <u>82,107</u>    |
| Net book value of property and equipment sold .....  |           | 160,244          |
|  |           | <u>242,351</u>   |
| Application of funds:  |           |                  |
| Acquisition of property and equipment .....  | \$184,808 |                  |
| Increase in General Trust Fund .....   | 7,211     |                  |
| Decrease in unamortized pension cost .....   | 29,900    |                  |
|  |           | <u>221,919</u>   |
| Increase in working capital .....  |           | <u>\$ 20,432</u> |
| Changes in the components of working capital:  |           |                  |
| Increase (decrease) in current assets:   |           |                  |
| Cash .....   |           | \$ 27,598        |
| Accounts receivable .....  |           | ( 1,822)         |
| Prepaid expenses and unamortized costs .....   |           | (34,439)         |
|  |           | <u>( 8,663)</u>  |
| Increase (decrease) in current liabilities:  |           |                  |
| Accounts payable .....   |           | 1,155            |
| Deferred membership dues .....   |           | (30,295)         |
| Other deferred income .....  |           | 45               |
|  |           | <u>(29,095)</u>  |
| Increase in working capital .....  |           | <u>\$ 20,432</u> |

(The accompanying notes are an integral part of the financial statements.)

(Continued on next page)

(Continued from previous page)

NOTES TO FINANCIAL STATEMENTS

1. In March 1971, the Association purchased one-half of the undivided interest in property located at 120 South Fourth Street, Columbus, Ohio, along with a 99-year leasehold on such property. The cost of one-half undivided interest on the property, including legal, auditing and architectural fees connected with the purchase, amounted to \$21,987. The cost of the 99-year leasehold amounted to \$137,944. During 1972, the Association sold such properties for \$166,524, realizing a gain of \$6,593, included in other income.

In October 1972, the Association purchased property located at 600 South High Street, Columbus, Ohio. The cost of the new property, including legal and surveying fees, amounted to \$182,200. On March 18, 1973, the Association contracted for the construction of a new office building for the Association amounting to \$466,050.

The Association provides for depreciation over the estimated useful life of the furniture and fixtures on the straight-line and declining-balance methods. Depreciation charged to operations during 1972 amounted to \$5,220.

2. The Association has a salaried employees' pension plan covering substantially all employees. Such plan has been approved as a qualified plan by the Internal Revenue Service under Section 401(a) of the Internal Revenue Code. At its inception, December 31, 1969, all costs of the plan which totaled \$386,900 were fully funded, and such prepaid or unamortized costs are being amortized on an actuarial basis each year. The costs applicable to 1972 operations totaled \$28,400, consisting of normal costs of \$5,800 and prior service costs of \$22,600.

The maximum provision for 1972 of \$28,400 included \$5,800 normal costs and \$34,200 which constitutes 10% of the frozen initial liability, reduced by interest of \$11,600 on the prepaid pension cost.

The actuarially computed value of vested benefits at December 31, 1972 amounted to \$331,300. The assets of the pension plan include the estimated applicable assets as actuarially computed at \$223,000 plus the unamortized prepaid pension costs on the balance sheet of the Association of \$245,000, totaling \$468,000 as of December 31, 1972.

3. The Association owns all of the outstanding stock of Ohio Medical Indemnity, Inc., 8,000 shares, having an equity of \$24,510,000 at December 31, 1972. The Board of Directors of Ohio Medical Indemnity, Inc. is prohibited from declaring or paying any cash dividends upon the common shares of the Corporation. In the event of any liquidation, each common shareholder shall be paid a sum equal to the price for which such shares are issued and sold by the Corporation. The remaining assets shall be distributed and transferred to the Association, or its successor organization, to be used solely and exclusively for medical research, medical education, or the development and establishment of medical care plans.

4. The income and expenses applicable to the operations of "The Ohio State Medical Journal" are as follows:

Income:

|  |                |
|--|----------------|
| Advertising (net of \$10,507 commissions and \$558 cash discounts) .....   | \$ 59,180      |
| Subscriptions received from nonmembers .....   | 1,228          |
| Membership subscriptions, allocated at \$4.50 per member's dues (included in membership dues in the Statement of Operations and Net Worth) ..... | 45,900         |
|  | <u>106,308</u> |

Expenses:

|   |                  |
|---|------------------|
| Salaries and payroll taxes .....  | \$50,298         |
| Printing, postage, stationery, supplies, illustrations and engravings ..... | 72,082           |
| Rent, depreciation and other .....  | 6,120            |
| Excess of expenses over income, Ohio State Medical Journal .....            | <u>\$ 22,192</u> |

5. The Ohio State Medical Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code.



Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritat-

ing symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

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# Allergy?

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INFLAMED, congested nasal passages are the cause of the symptoms of nasal stuffiness, drip and congestion. Dimetapp Extentabs® effectively relieve these symptoms by acting on the nasal mucosa. Dimetapp Extentabs® is a combination of three active ingredients: Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; and phenylpropanolamine HCl, 15 mg. Dimetane® is an antihistamine that relieves the allergic reaction. Phenylephrine and phenylpropanolamine are vasoconstrictors that reduce the swelling of the nasal mucosa. Dimetapp Extentabs® is indicated for the relief of nasal congestion, drip and stuffiness in the treatment of colds, hay fever, and allergic rhinitis. Dimetapp Extentabs® is a combination of three active ingredients: Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; and phenylpropanolamine HCl, 15 mg.

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## Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

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the analgesic formula that calms instead of caffeinates

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Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital ( $\frac{1}{4}$  gr.), 16.2 mg (warning: may be habit forming); Aspirin ( $2\frac{1}{2}$  gr.), 162.0 mg; Phenacetin (3 gr.), 194.0 mg; Codeine phosphate,  $\frac{1}{4}$  gr (No. 2),  $\frac{1}{2}$  gr (No. 3) or 1 gr (No. 4) (warning: may be habit forming).

**Indications:** Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

Ⓒ Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. **A-H-ROBINS**



# Statistical Division of Health Department Gives Some Interesting Data on Ohio

SOME INTERESTING INFORMATION on the population of Ohio, regarding birth, life, death, marriage, divorce, and especially numerical trends in these categories is revealed in the 1972 Annual Report on "Vital Statistics," published by the Division of Vital Statistics, Ohio Department of Health.

The total population of Ohio as of April 1, 1970 was 10,652,017.

The "trend tables" are especially interesting. Live births hit a peak of 26.4 per 1,000 population in 1954. After 1957 there was a gradual decrease to 15.9 per 1,000 population in 1972. In 1930, only 24.8 percent of births were in hospitals. In 1972, the percentage was 99.5. The inhospital births had held at 99.6 for the previous three years.

The death rate per thousand population decreased from 11.4 in 1930 to 9.6 in 1972. The white population death rate was 11.1 in 1930 compared with 9.5 in 1972. There was a marked drop in the nonwhite rate, from 18.3 per thousand in 1930 to 9.9 in 1972.

There were great differences in infant death rates over the 42-year period. In 1930, the infant death rate was 61.3 per thousand live births compared with 18.0 in 1972. The rate for white infant deaths was 58.9 in 1930 and 16.2 in 1972; while among nonwhite infant deaths, the rate was 104.3 in 1930 and 29.0 in 1972.

An even more remarkable difference in maternal deaths is shown. In 1930 there were 57.6

maternal deaths per 10,000 (ten thousand) live births, while by 1972 the rate had dropped to 1.7. The rate for white maternal deaths was 55.4 in 1930 compared with 1.4 in 1972; while the non-white rates was 96.9 in 1930 compared with 3.9 in 1972.

A 23-year trend in marriages shows that they hit a low in 1957 of 6.4 per thousand population, but are up to 9.0 in 1972. Over the same period, divorces hit a low in the 1958-1963 period, but have been on the rise since, reaching 4.2 per thousand in 1972.

Heart, cancer and stroke continued to be way out front in causes of deaths, accounting for 71.2 percent of female deaths and 67.2 percent of male deaths. Following are the ten most common causes of deaths:

| <i>Cause of Death</i>                              | <i>Percent</i> |
|--|----------------|
| Diseases of Heart                                  | 40.2           |
| Malignant Neoplasms                                | 18.0           |
| Cerebrovascular Disease                            | 10.8           |
| Accidents  | 5.2            |
| Influenza and Pneumonia                            | 2.9            |
| Diabetes Mellitus                                  | 2.3            |
| Arteriosclerosis                                   | 2.0            |
| Bronchitis, Emphysema, and Asthma                  | 1.9            |
| Certain Causes of Mortality in<br>in Early Infancy | 1.7            |
| Cirrhosis of Liver                                 | 1.4            |
| Other Deaths                                       | 13.6           |

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# Clinical & Scientific Features



VOLUME 69

NOVEMBER 1973

NUMBER 11

## Total Knee Replacement – Its Current Significance

THOMAS H. MALLORY, M.D.

IN VIEW OF THE EXCELLENT results being obtained with total hip replacement, the current status of total knee replacement should be evaluated. The knee is a more complicated joint than the hip because of its multiaxes of motion, which allow flexion, rotation, and slide. The ideal total knee replacement design should have the capacity to duplicate these multiaxes of motion. In addition, it should offer relief of pain and rapid restoration of function as well as durability and the capacity to correct long-standing contracture or deformity.

There are several sophisticated total knee prostheses with which the practitioner should be familiar. They consist of matched components made of metal alloy and high density polyethylene plastics. The metal and plastic joints are secured to the bone with polymethylmethacrylate (bone cement). The two basic designs that have been developed are the Geomedic and the Polycentric Total Knee Replacement.<sup>1,2</sup>

The Geomedic total knee replacement is a two-part design involving a metal femoral com-

ponent which articulates with a plastic tibial plateau (Fig. 1). The units are rigidly fixed to the bone with methylmethacrylate, which offers immediate and firm fixation. The Geomedic knee has inherent stability and is technically easy to insert.

The Polycentric knee, on the other hand, tends to duplicate knee function without regard to anatomic design (Fig. 2). The Polycentric knee is more flexible in its application than the Geomedic knee. For example, if only one compartment of the knee is involved, the Polycentric knee can be used as a single unit. If varus or valgus deformity is present, then correction can easily be obtained by mismatching the femoral components.

The selection of patients for total knee replacement in its current form is critical. As in total hip replacement, the patient should have far-advanced, intra-articular arthritis of the knee. However, a certain amount of inherent stability is necessary in the knee in order to keep the total knee replacement components in their proper articulating relationships. Flexion, valgus, or varus deformities of the knee should not exceed 30 degrees. The patient should be fully ambulatory and have functional quadriceps and hamstring musculature. The total knee replacement, in its

current form, will not suffice for the patient who is nonambulatory or who has severe contractures of his knees. It is important for the practitioner to understand these critical points for proper patient selection.

### Procedure

Total knee replacement is not an operation of major surgical stress. The essence of this surgery consists of removing bony articulating surfaces and interposing metal implants on the femoral condyles and plastic platform or tracks on the tibial plateau. These implants are fixed with methylmethacrylate (bone cement). After surgery, the patient is kept immobilized for approximately five to seven days. With proper exercise and physical therapy, the patient generally gains 90 degrees of motion within ten days after his surgery. The patient is discharged from the hospital two to three weeks after surgery.

### Material

Twenty prostheses of the Polycentric type have been inserted by the author in 16 patients. Ten of the patients were women and six were men. The average age was 58 years, with the youngest patient being 23 and the oldest 70 years old. Hospitalization averaged 22 days.

### Subjective Evaluation

Preoperatively, all the patients had severe pain, which they considered to be their primary disability. Pain and loss of motion were disabling in 13 patients, and pain and instability were major problems for three patients. At the time of last follow-up, 18 of the 20 patients (90 percent) were reported as entirely painless or they had no more than mild-to-intermittent discomfort. The slight discomfort did not limit the patient's activity

## The Author

• Dr. Mallory, Columbus, is a member of the Attending Staffs, Mount Carmel and Riverside Methodist Hospitals; and Clinical Instructor, Division of Orthopaedic Surgery, The Ohio State University College of Medicine.

nor was medication required. In one patient, pain was not relieved. In the other patient, mild-to-moderate pain occurred intermittently and occasionally required analgesic medication.

### Objective Evaluation

Preoperatively, passive range of motion was from 15 to 100 degrees of flexion. Average active range of motion was from 20 to 90 degrees of flexion. Quadriceps and hamstring power were rated as 60 percent of normal. Contracture or pain oftentimes made it impossible to rate muscle power adequately.

Postoperatively, the average passive range of motion was 5 degrees of fixed flexion to 110 degrees of further flexion with active average range of motion ranging from 5 to 100 degrees of flexion. At the end of six months postoperatively, the average quadriceps power was approximately 80 percent of normal. Correction of varus or valgus deformity of approximately 30 degrees preoperatively was corrected to 5 degrees postoperatively.

### Complications

There was one wound dehiscence, which was managed by secondary closure. There were no wound infections, superficial or deep. There was



FIG. 1. GEOMEDIC TOTAL KNEE REPLACEMENT

Preoperative (left) and postoperative (right) x-ray films showing single metal femoral component and plastic tibial plateau. Fixation is with methylmethacrylate (bone cement).



FIG. 2. POLYCENTRIC TOTAL KNEE REPLACEMENT

Preoperative (left) and postoperative (right) x-ray films showing runner-like femoral metal components articulating in plastic tibial tracks. Fixation is with methylmethacrylate.



one stress fracture beneath the medial tibial plateau and there was one dislocation. One developed persistent, 30-degree flexion contracture, which later required manipulation.

### Discussion

The purpose of this paper is to present to the practitioner the current concepts of total knee replacement, emphasizing a particular experience with the Polycentric total knee. Of 16 patients in which 20 Polycentric total knee replacements were performed, over 90 percent had complete relief of pain or only mild residual discomfort, which did not require analgesic medication. In all patients, improved range of motion was accomplished, and all patients were fully ambulatory either with a cane or with no aids at all. There were no wound infections. The materials have been well tolerated to date, and there has been only an occasional complication related to the surgery itself.

One can conclude that the early results of total knee replacement in this particular series are

encouraging. There are, however, unanswered questions concerning total knee replacement as there are in other types of joint replacement. Experience to date is short-ranged. Therefore, it is recommended that the selection of patients for total knee replacement should be limited to the elderly with end-stage knee disease.

### Summary

Designs and concepts of total knee replacement have been discussed. Twenty Polycentric total knees in 16 patients were presented. Early results were encouraging both for relief of pain and improved function. Total knee replacement in its current status is indicated in elderly individuals with far-advanced, end-stage knee disease.

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## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

This 32-year-old man enters your office with lesions in both nostrils. (See figure.) They have been present for six months and have gradually enlarged. What is your clinical impression and how may these lesions be managed?

(See p. 840 of this issue for further information and discussion.)



These lesions have been present in both nostrils for six months.

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Submitted July 12, 1973.

# Vitamin E: Who Needs It?

## II. Diseases Associated with Vitamin E Deficiency

DAVID K. MELHORN, M.D.

IN PART I of this review, discussion was focused on a pathogenic state in the human which is clearly related to vitamin E deficiency, vitamin E-dependent hemolytic anemia in the premature infant.<sup>1</sup> This section considers the significance of vitamin E (tocopherol) deficiency in a variety of disease states in which the effects of the vitamin lack are unclear.

### Causes of Vitamin E Deficiency

1. *Dietary Lack.* Since tocopherols are present in such a large variety of foodstuffs, vitamin E deficiency resulting from dietary lack is extremely rare. Children suffering from severe generalized malnutritional disorders have been reported to demonstrate tocopherol lack in addition to protein and other vitamin deficiencies.<sup>2</sup> We have also observed several infants in the age range of 5 to 12 months who demonstrated vitamin E deficiency in association with marked iron and protein lack. Although no specific clinical benefit from vitamin E administration was seen in our patients, children studied by Majaj<sup>2</sup> responded to vitamin E therapy with improvement in hemoglobin concentration. Although such observations indicate that vitamin E deficiency can occur solely on the basis of nutritional deprivation, the difficulty in designing low tocopherol diets for the production of experimental vitamin E deficiency in normal, human adult subjects<sup>3</sup> indicates the infrequency with which diet-induced tocopherol lack is found.

2. *Intestinal Malabsorption.* Because tocopherols available from dietary sources consist of

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a number of fat-soluble forms of the vitamin, it is predictable that the majority of diseases associated with vitamin E deficiency are those in which intestinal malabsorption of fats is a cardinal feature. Although the association between vitamin E lack and defects in fat absorption has been identified in a variety of illnesses, the model herein considered is cystic fibrosis.

Cystic fibrosis (CF) is characterized by a relative inability to absorb fats and fat-soluble vitamins because of inadequate pancreatic secretion of enzymes necessary for assimilation of fats.<sup>4</sup> The following case history of a patient with CF illustrates both the association between vitamin E and the primary disorder, and the dilemma posed by attempts to correlate laboratory abnormalities.

### Case History

S.P. is a 12-year-old white girl. Following a normal newborn period, her infancy was characterized by frequent respiratory infections and poor weight gain. She was first hospitalized at the age of 4 years for pneumonia, at which time a sweat chloride determination confirmed the diagnosis of CF.

The patient was subsequently placed on an intensive care program, which included pulmonary drainage, mist tent therapy, intermittent antibiotics as indicated by results of sputum cultures, and medications which consisted of pancreatic enzymes, a multivitamin preparation, and vitamin E in a daily dose of 100 international units (I.U.) of alpha-tocopherol acetate. During the subsequent eight years, therapy was maintained but did not prevent a gradual deterioration of lung function. When hospitalized again at the age of 12 years, the patient also manifested growth failure accompanied by increased

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Reprint requests to Rainbow Babies and Childrens Hospital, 2103 Adelbert Road, Cleveland, Ohio 44106 (Dr. Melhorn).

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appetite and steatorrhea. Additional complaints included lethargy, vague weakness in the lower extremities, and intermittent thigh and calf pain. Relevant laboratory findings at the time of this admission are shown in Table I.

Special studies were undertaken to evaluate the patient's vitamin E status. As in Part I of this review, serum-free tocopherol was determined by a slight modification of the method of Quaife, et al,<sup>5</sup> using 0.6 ml of serum with proportional readjustment of the reagents. Vitamin E tolerance curves were performed according to a modification of the method of Filer and others<sup>4</sup> previously described.<sup>1</sup> In addition to alpha-tocopherol acetate, another form of tocopherol was used in tolerance studies in this patient and other subjects mentioned herein. This second form, alpha-tocopherol polyethylene glycol 1000 succinate (supplied by Ross Laboratories, Columbus, Ohio) is considered a water-soluble compound.<sup>6</sup> Erythrocyte hydrogen peroxide (H<sub>2</sub>O<sub>2</sub>) hemolyses were determined by the technique of Gordon, et al.<sup>7</sup>

Table 2 shows serum vitamin E levels and red cell H<sub>2</sub>O<sub>2</sub> hemolyses during courses of vitamin E therapy with both alpha-tocopherol acetate (TA) and alpha-tocopherol polyethylene glycol 1000 succinate (TPEGS). It should be first noted in examining this table that the patient's serum vitamin E level was abnormally low (by the definition established in previously reported work,<sup>5,7</sup> a serum tocopherol level below 0.50 mg per 100 ml represents vitamin E deficiency. Normal values in this laboratory range between 0.70 mg per 100 ml and 1.40 mg per

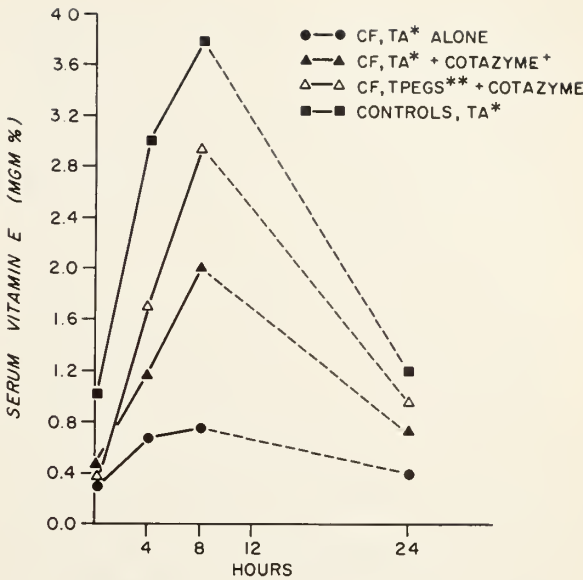


FIG. 1. Mean vitamin E absorption curves in children and adults with cystic fibrosis compared with control subjects. \*TA = alpha-tocopherol acetate, \*\*TPEGS = alpha-tocopherol polyethylene glycol 1000 succinate. †Cotazyme = pancreatic enzyme preparation.

100 ml). She had been receiving a large supplemental dose of alpha-tocopherol acetate for years before initial vitamin E levels were determined. At the same time, red cell H<sub>2</sub>O<sub>2</sub> hemolysis was abnormally elevated, as was the erythrocyte level of malonyldialdehyde (MDA), a measure of the degradation products of red cell lipids. The MDA level, as determined by the method of Stocks and Dormandy,<sup>8</sup> was 365 n moles per gm hemoglobin (normal range in this laboratory is 130 to 180 n moles per gm hemoglobin). Thus, oral administration of even large amounts of a fat-soluble form of tocopherol in this and other patients with intestinal malabsorption of fats may be quite erratic, even when fat-soluble tocopherol supplements are given.

Figure 1 shows mean vitamin E tolerance curves in other CF patients with and without coincident administration of pancreatic enzymes, compared with normal subjects of similar age. Also shown are mean values in patients with CF who received their tolerance test doses of tocopherol as TPEGS. It is obvious that the best intestinal absorption of tocopherol in patients with CF is accomplished by the combined use of TPEGS and a pancreatic enzyme preparation.

Table 3 records serum vitamin E levels, red cell H<sub>2</sub>O<sub>2</sub> hemolysis, and MDA levels in patients with other diseases in which absorption of fats is impaired. The close relationship between vitamin E deficiency, abnormal red cell H<sub>2</sub>O<sub>2</sub> hemolysis and MDA is again noted, although the pathogene-

TABLE 1. Hematologic Parameters in Patient S.P.\*

|   |                      |
|---|----------------------|
| Hemoglobin                              | 10.9 gm%             |
| Hematocrit                              | 33%                  |
| Reticulocyte count                      | 2.0%                 |
| White blood cell count                  | 8560/mm <sup>3</sup> |
| Total serum protein                     | 5.7 gm%              |
| Serum folic acid                        | 8 nanograms/ml       |
| Serum vitamin B <sub>12</sub>           | 413 picograms/ml     |
| Bound serum iron                        | 55 ug%               |
| Total iron binding capacity/%saturation | 260 ug%/21%          |

\*While receiving alpha tocopherol acetate, 100 I.U./day.

TABLE 2. Vitamin E Levels and H<sub>2</sub>O<sub>2</sub> Hemolysis in Patient S.P.

|  | TA*  | TPEGS† | Normal Controls<br>(Mean and Range) |
|--|------|--------|-------------------------------------|
| Serum vitamin E (mg%)                                | 0.15 | 0.65   | 0.92<br>(0.70-1.40)                 |
| Red cell H <sub>2</sub> O <sub>2</sub> hemolysis (%) | 68   | 24     | 6<br>(0-13)                         |

\*Alpha-tocopherol acetate, 100 I.U./day, taken for eight years.

†Alpha-tocopherol polyethylene glycol 1000 succinate, 100 I.U./day, taken for two weeks.

sis of the diseases is quite varied. Patients with a beta-lipoproteinemia are also known to have depressed serum tocopherol levels.<sup>9</sup> In this disease, however, absorption, transport, and perhaps metabolism of lipids and fat-soluble vitamins may all be abnormal.

In all of the disease states previously mentioned, the dilemma of evaluation of clinical response to administration of vitamin E is evident. The response of the patient in our case history exemplifies the nature of the problems. First, as noted, it cannot be presumed that patients with malabsorptive disorders who receive supplemental vitamin E, even in large amounts, can maintain vitamin E sufficiency. Second, although there appears to be a direct relationship between plasma serum tocopherol levels and tissue stores in normal individuals, this may not be the case in certain disease states.<sup>10</sup> Third, as was the case in patient S.P., absorption of tocopherol may depend upon the form in which it is supplied. The normal individual appears to absorb equivalent amounts of the various analogues of vitamin E equally well, but in patients whose absorption of fats is impaired, a water-soluble form of the vitamin such as TPEGS may be much more effective in maintaining vitamin E sufficiency. For example, S.P. achieved a normal vitamin E level with coincident decreases in red cell H<sub>2</sub>O<sub>2</sub> fragility and MDA values within two weeks after therapy with TPEGS was begun.

Finally, it is often extremely difficult to relate improvement in in vitro laboratory findings to changes in clinical status once vitamin E sufficiency is attained. S.P. showed an appreciable clinical improvement during the six weeks following institution of TPEGS therapy. However, this improvement appeared related primarily to intensive pulmonary care and antibiotics. There was no significant change in the hemoglobin and hematocrit values, or the reticulocyte count. The fact that such in vitro determinations as red cell H<sub>2</sub>O<sub>2</sub>

TABLE 3. Vitamin E Levels and Related Studies in Patients with Malabsorptive Disorders

|   | Mean<br>Vitamin E<br>(mg %) | Mean<br>H <sub>2</sub> O <sub>2</sub><br>Hemolysis | Mean<br>MDA<br>(nm/gm hgb) |
|---|-----------------------------|--|----------------------------|
| Celiac disease<br>(3 patients)          | 0.24                        | 85   | 285                        |
| Chronic diarrhea<br>(12 patients)       | 0.45                        | 68   | 225                        |
| "Short bowel" syndrome*<br>(5 patients) | 0.40                        | 65   | 310                        |
| Biliary atresia                         | 0.18                        | 92   | 380                        |
| Normal controls                         | 0.92                        | 6  | 148                        |

\*Intestinal obstruction requiring surgical resection

hemolysis and MDA returned to normal is of interest, but is difficult to relate to the clinical course in these patients.

Effects of vitamin E deficiency such as shortened red-cell survival time,<sup>11</sup> deposition of ceroid pigment in the smooth muscle layer of the intestine (sometimes called the "brown bowel syndrome"<sup>12</sup> because of the gross appearance of the intestine as seen at autopsy), and evidence of degeneration of striated muscle fibers<sup>13</sup> have been described. However, no definite evidence for improvement in these conditions upon achievement of vitamin E sufficiency has been shown.

3. *Other Mechanisms of Vitamin E Deficiency.* Until this point, we have been discussing the confirmed and possible effects of vitamin E lack occasioned by dietary deficiency or intestinal malabsorption, and have assumed that the deleterious effects of tocopherol deficiency are the result of decreased ability of cellular systems to deal with peroxide stress on the lipid components of cellular membranes. However, there are other circumstances under which a dietarily "adequate" intake and normally efficient absorption of the vitamin might not be sufficient to maintain appropriate serum or tissue levels of tocopherol.

This situation could occur in several ways; two possibilities will be considered here. First, it

TABLE 4. Human Vitamin Deficiency States

| Disease Examples   | Cause of Vitamin E Deficiency  | Reported Manifestations   | Response to Vitamin E   |
|--|--|---|---|
| Group 1<br>Generalized malnutrition  | Dietary lack   | Megaloblastic anemia  | Improvement of anemia   |
| Group 2<br>Prematurity<br>Cystic fibrosis<br>Steatorrhea<br>Chronic diarrhea | Intestinal malabsorption<br>Intestinal malabsorption<br>Intestinal malabsorption<br>Intestinal malabsorption | Hemolytic anemia<br>Shortened RBC survival;<br>ceroid deposition; muscle<br>degeneration. | Improvement of anemia<br>Uncertain  |
| Group 3<br>A-beta-lipoproteinemia  | Unclear  | Possible shortened RBC survival   | Uncertain   |
| Group 4<br>Congenital dyserythropoiesis                                      | ? Increased utilization  | Anemia, shortened RBC survival time,<br>hyperbilirubinemia.                               | Improvement of anemia,<br>RBC survival and<br>disappearance of<br>hyperbilirubinemia. |



has been suggested, as noted in Part I of this review, that the requirements for tocopherol in biologic systems are not so much related to the absolute amount absorbed as to the types and quantities of dietary fats ingested.<sup>14</sup> This relationship is often expressed in terms of the ratio of vitamin E intake to intake of polyunsaturated fatty acids (E/PUFA). It is conceivable, therefore, that the amount of tocopherol ingested in an "average diet," coupled with a high intake of PUFA could result in increased utilization of vitamin E, via its consumption in protection of unsaturated lipid bonds against peroxidation, and consequent vitamin E depletion. As previously discussed,<sup>1</sup> the high content of PUFA in formulas fed to premature infants may contribute to the tocopherol deficiency frequently encountered in prematurity. However, the E/PUFA ratio has not yet been shown to be clinically important in older children and adults in whom vitamin E deficiency is found.

It is also possible, at least theoretically, that disease states exist in which the dietary intake and absorption of tocopherol is normal, but vitamin E lack results because the basic disease process manifests defects which force the cellular mechanisms responsible for maintaining structural integrity to "work overtime." Following an oral suggestion by B. H. Lubin, M.D., in September 1972, attention in our laboratory has recently been focused on relationships between various forms of hemolytic anemia and vitamin E function. In at least one of the patients so studied,<sup>15</sup> an 8-year-old girl with congenital dyserythropoietic anemia, vitamin E deficiency was related to increased utilization of the vitamin rather than to dietary lack or malabsorption. Heightened utilization of vitamin E appeared to reflect an attempt to stabilize the lipid components of abnormally constructed erythrocyte membranes. Achievement of vitamin E sufficiency in this patient was accompanied by partial correction of her anemia, and disappearance of the hyperbilirubinemia which had been present since infancy.

Table 4 summarizes disease states in which vitamin E deficiency has been documented. In all pathophysiologic situations noted, tocopherol deficiency is a *secondary* feature of the disease process, with the rare exception of nutritional deprivation. Vitamin E may, but *only* may have additional

contributory effects, and the response to vitamin E therapy in these illnesses is variable.

In part III of this review, the myriad of conditions in which vitamin E therapy has been employed in the absence of demonstrable tocopherol deficiency will be explored. This area of information about vitamin E is most complex, most confusing, and in part, most amusing.

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# Obstetric and Gynecologic Effects of the Ileal Shunt

MELVERN A. AYERS, M.D.

THE PROBLEMS OF OBESITY are well recognized by all physicians. The markedly overweight patient has decreased longevity and increased problems of cardiovascular and pulmonary disease; metabolic disorders, such as diabetes and gout; gastrointestinal disease; degenerative joint disease; and gynecologic disorders (abnormal menstrual patterns, infertility), and other problems. Also, the insulating fat pad of the abdominal wall makes auscultation of the fetal heart, palpation of the fetal parts, and the assessment of contractions much more difficult. The obese woman, pregnant or not, presents a multitude of problems to the obstetrician-gynecologist.

The treatments of obesity are variant and often fail. This failure of treatment may be: (1) lack of sufficient patient cooperation in maintaining a proper balanced diet, or (2) that a helpful medication program must be on a temporary basis, because of the dangers in the prolonged use of the amphetamine family of drugs, or (3) a "conditioned" physician can no longer be enthusiastic about the "help me, doctor" pleas of another 104.4-kg (230 lb) lady.

Unfortunately, many patients fail to maintain their weight loss after a successful program has been ended. Physicians feel that in some obese patients, refractory to standard management, there is a chronic ingestion of increased calories, denied or not, that is the prime basis for their problem.

A surgical treatment of obesity was reported in 1963 by Payne, De Wind, and Commons relating their experience with weight loss following a temporary jejunocolic shunt.<sup>1</sup> Their patients, on reaching a predesired weight, had bowel continuity reestablished and in most instances, regained

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their initial obese state. Other physicians have used both temporary and permanent intestinal by-pass procedures to create weight loss in obese patients.<sup>2</sup>

Starting in 1962, a slowly evolving surgical and medical treatment for permanent control of obesity was developed at Henry Ford Hospital in Detroit. Under direction of Dr. Boy Frame, an internist, and Dr. James Barron, a surgeon, a group of patients, including 27 women, were thoroughly studied, including psychiatric assessment, and underwent a surgical by-passing of a portion of the small bowel. These 27 women, age 18 to 50 years had long-standing obesity with weights up to 155.6 kg (345 lb). After intensive evaluation, the permanent by-pass procedures of jejuno-ileostomy, jejunocolostomy, or jejunocecostomy were completed.<sup>3</sup>

## **General Effects**

All the patients lost weight by a rapid, steady drop to a stabilizing level in 6 to 12 months.

Medically managed postoperative complications were orthostatic hypotension, anal fissure, dehydration, rheumatoid arthritis-like symptoms, renal calculi, tetany, gastric ulcer, easy bruising, hepatic failure, and refractory anemia.

Surgically-managed postoperative complications included correction of internal hernia, revision

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of shunt and takedown of shunt, partial bowel obstruction with intussusception, ventral hernia, and lipectomy for massive skin folds.

Diarrhea was a common complaint among patients with the sequelae of anal discomforts. More than half had more than four bowel movements per day. Increased flatus, bloating, weakness, rectal pain, and hemorrhoids were frequently mentioned. Other lesser-mentioned complaints included dry skin with sagging, myalgia, arthritic problems, the ordeal of the postoperative period, and the taking of medicine. The majority of these patients take daily vitamin B-complex with vitamin C, vitamin D, iron, folic acid, calcium carbonate, potassium, and antispasmodics. Monthly vitamin B<sub>12</sub> injections are given.

Two patients have died since surgery. The first was a 44-year old woman with a 20-year history of obesity who died from pulmonary infarction five months after surgery. Her weight loss had been from 155.6 kg (345 lb) to 113.5 kg (250 lb). The second patient was a 42-year-old woman who died nine months after surgery from hepatic and renal failure. Her weight loss had been from 145.3 kg (320 lb) to 90 kg (198 lb).

The patient response was enthusiastic. All were satisfied with the results of the operation regarding weight reduction, the changes in relationships to friends and family, plus a much-improved body image. All would have the operation again under similar circumstances. Only one would not advise others to have the operation. Although most people ate more after surgery, six stated they ate less.

When asked by survey what were the major advantages, they responded in this order of frequency: (1) improved self image, (2) loss of weight and improved health, (3) increased physical activity, (4) decreased emphasis on food and eating without guilt, and (5) decreased sweating.

### Obstetric Effects

Only four of these 27 women have become pregnant after a shunt procedure. One miscarried at seven weeks, and three have carried a pregnancy to term after a shunt procedure. The first, M.K., delivered her third pregnancy at Henry Ford Hospital in 1961 prior to her surgery. The pregnancy was complicated by hypertension with systolic pressures up to 160 mm Hg and diastolic pressures up to 98 mm Hg. She was hospitalized at 25 weeks for excessive weight and toxemia of pregnancy. Barbiturates, diuretics, and anorectic agents were used. Weighing 108 kg (238 lb), she delivered a normal 3.3-kg (7 lb 4 oz) boy at term. In the delivery room, her blood pressure rose as high as 210/150 mm Hg. Magnesium sulfate, barbiturates, and other measures were used successfully.

In her fourth pregnancy in 1965 after surgery, her weight dropped from 94 kg (207 lb) in the

second month of pregnancy to 84.4 kg (186 lb) at term. No barbiturates were needed to control her blood pressure which averaged about 130/80 mm Hg. No albuminuria was noted. On one occasion pedal edema was noted, but no diuretics were used because of previously recognized low potassium levels in this patient. She delivered at term, without problem, a normal 2.8-kg (6 lb 13 oz) girl whose growth and development have been normal.

The second patient, L.G., had the shunt procedure in March 1964. She was seen late in 1965 with subjective symptoms of pregnancy. Her last menstrual period was October 31, 1965; her weight was 57.7 kg (127 lb). Gravida 3, para I, her prior obstetrical history included a first-trimester abortion in 1958, and a term delivery of a 2.8-kg (6 lb 4 oz) girl in 1960. During that pregnancy, her weight had risen from 81.2 kg (179 lb) to 104.4 kg (230 lb) with recorded blood pressures up to 220/100 mm Hg. She was hospitalized for two weeks post partum because of persistent increased blood pressure and albuminuria. In the pregnancy following the shunt, the weight range was 57.6 to 58.6 kg (127 to 129 lb), the blood pressure averaged 130/80 mm Hg, and no albuminuria was noted. Serum potassium levels of 4.0 mEq/liter in January 1965, and 3.3 mEq/liter in March 1965 were corrected by oral supplements. She was delivered of a 2.3-kg (5-lb) boy, without problem, at term. We were concerned at delivery with the weight of the child, however, both growth and development have been normal.

Both of these women have been studied by Dr. Arthur B. French in Ann Arbor at the Clinical Research Unit of the University of Michigan Hospital for many metabolic parameters (written communication, July 1966).

The first patient was studied with three different sodium intakes: 64, 132, and 410 mEq/liter, each fed for a period of six days. (On the intake of 64 mEq/liter, the negative sodium balance was 69 mEq/liter for six days; on the 132 mEq/liter diet, it was a negative 43 mEq/liter for six days; and on the 410 mEq/liter diet, there was a positive balance of 310 mEq/liter for six days.) Thus, Mrs. M. K. could easily become sodium depleted on mild sodium restriction, but such depletion could be adequately avoided by liberal use of salt on her food. Chloride losses almost exactly paralleled sodium losses with a total negative chloride balance of 201 mEq/liter for the 18 days.

Dr. French summarized by stating: "She has reduced weight and shows excellent general nutritional status after small intestinal by-pass with jejunocolostomy. There are no clinical signs of specific nutritional deficiencies. There are substantial increased fecal losses of fat and nitrogen, mildly increased losses of calcium and slightly increased sodium loss. It should be possible to com-

pensate these increased losses by mild dietary modifications without medicinal supplementation."

The second patient, L. G., was summarized by French as: "... has shown good stabilization of weight at a highly satisfactory level following jejunocolostomy. There is chemical evidence of low iron stores, however, she shows no evidence of depleted stores of other minerals."

The third patient was a 27-year-old woman whose prior pregnancies had been complicated by toxemia and preeclampsia requiring multiple hospitalizations. She conceived her third pregnancy three months after surgery at 118 kg (260 lb), and lost to 103 kg (227 lb) at delivery. Neither albuminuria nor edema was noted and the highest blood pressure recorded was 160/100 mm Hg during the prenatal course. She delivered at term a 3.2-kg (7-lb), healthy girl whose growth and development have been normal.

### Fetal Effects

Certainly all obstetricians recognize the relationships of maternal obesity to toxemia of pregnancy. With the marked reduction in weight, the prenatal course in the women we studied was much more normal after the surgical procedure than before. However, certain thoughts and observations suggest that subtle fetal effects may be present.

The second baby was delivered at term weighing only 2.3 kg (5 lb). My first thought on seeing the baby was "runt syndrome." Then a few hours later, the pediatrician thought the baby had a peculiar facies, low-set ears, and other peculiarities, suggesting the syndrome of idiopathic hypercalcemia with associated aortic stenosis, mental retardation, and delayed development. Although not proven in the child, it does bring to mind the possibility that overnutrition of the mother can affect the offspring. Both of these women received many supplements including vitamin D and calcium as previously noted. Cochrane warns that physicians have only limited knowledge concerning effects on the fetus of maternal nutritional excesses.<sup>4</sup>

Fortunately, by the end of the child's first year of life, his growth and development were perfectly normal. However, we continue to wonder if the by-pass procedure could cause fetal deprivation of varying types. For example, reduction of essential fatty acids may cause inadequate fetal CNS development in animals.<sup>5</sup> From other indirect studies not yet published, J. A. Churchill, M.D., using sibling comparison data, has found that inadequate rates of weight gain of mothers in the last half of pregnancy may be related to decreased I.Q. (oral and written communications, November 1968). The findings suggest that inadequate maternal weight gain may be paralleled by insufficiencies of nutrients required for optimum

brain formation in utero. In a report from the Collaborative Study of Cerebral Palsy, Singer, et al, state: "Higher maternal weight gain is also associated with better growth and performance in the infant's first year of life."<sup>6</sup> Some of these patients represent weight loss during pregnancy. We do not have enough experience to be confident in answering the question: "May I have a normal pregnancy after my operation?"

Payne, et al<sup>1</sup> relate the case of a 25-year-old white woman whose menstrual cycles returned to normal five months after a jejunocolic shunt and a loss from 109.8 kg (242 lb) to 53.5 kg (118 lb). Two years later, a jejuno-ileal by-pass was made. Within two months she became pregnant, gained to 77.2 kg (170 lb), and delivered. Since her second procedure, she has delivered three children successfully.

Charles B. Porter, M.D., in a private-practice series of 85 patients from the Western Michigan area, related that five of his patients have successfully delivered following a by-pass procedure (oral and written communications, October 1967). One patient who delivered twins, had a preoperative weight of 177.6 kg (391 lb) and lost over 90.8 kg (200 lb).

Successful pregnancies are possible even during the acute weight loss phase, but we advise that two years of dietary stabilization pass before conception be attempted.

The gynecologic effects of the surgery also are difficult to evaluate as these women are often abnormal before surgery and many were near menopause. However, during the period of rapid weight loss, many of the women become amenorrheic, or have erratic periods. In the older premenopausal ladies, definite estrogen deprivation signs and symptoms occur. Anovulatory temperature patterns are noted in the younger women, which change, however. One patient ceased to menstruate in her mid-20's as her weight rose to 113.5 kg (250 lb). The mother of four, she became amenorrheic for six years, had the operation, and as her weight dropped, her periods started in a normal ovulatory pattern.

With improvement of weight, the patient's "body image" improved to the satisfaction of both husband and self. Marital relations have improved in nearly all cases. One notable exception was a lady who had marital relations approximately three times daily when obese, but now thin, she reports relations only three times weekly.

A very common complaint is recurrent vaginitis. Various operative procedures, including a myomectomy were performed with no clotting deficiencies, wound healing, or other problems.

### Summary

An intestinal by-pass procedure may benefit the obese patient in many ways. Three patients



have been delivered of apparently normal infants after a by-pass procedure. However, it is felt that postponement of pregnancy is advisable until a weight stabilization has occurred. No significant gynecologic problems have been noted.

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## Central Venous Pressure Simple Method for Setting Manometer

JAMES A. GOLDEY, M.D.\*

THE FOLLOWING is a rapid, simple, and accurate method for setting the zero level of a central venous pressure manometer:

1. Measure the anteroposterior diameter of the patient's chest. With a ballpoint pen, make an "X" on the skin of the lateral chest at a point representing the level of the entrance of the vena cava into the right atrium. (For adults, 10 cm above the bed, or one-half the anteroposterior diameter measured at the left fourth interspace at the sternal border is commonly used.)

2. Fill a piece of clear plastic tubing with water and clamp both ends. Length is not im-

portant. However, the bore of the tubing must be great enough to avoid capillary effect and air lock. Intravenous tubing is too small. The kind used in disposable enema sets is ideal.

3. Hold one end of the tubing vertically next to the mark on the patient's chest. Hold the other end vertically next to the manometer and remove the clamps. The tubing will be roughly in a U shape.

4. Raise or lower both ends of the tubing to adjust the water level to the mark on the patient's chest.

5. The water levels will be equal. Simply slide the manometer up or down so that the zero point is at the level of the water in the tube.

6. Reclamp the ends of the tubing until it is needed again.

The entire procedure takes less than ten seconds, and can be easily repeated when the patient is moved up or down in bed.

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Submitted March 23, 1973.

# Multifocal Osteosarcoma

## A Case Report

SEBASTIAN A. COOK, M.D.; ANTHONY F. LALLI, M.D.; AND ALAN H. WILDE, M.D.

OSTEOSARCOMA usually presents as a single bone lesion which subsequently metastasizes to the lungs. Multifocal osteosarcoma is a rare disease which was first described in the literature in the late 19th century. An excellent review of this entity was published by Amstutz<sup>1</sup> in 1969. Since then there have been no case reports. Whether this entity represents metastatic lesions or is indeed a multicentric phenomenon has been a controversial point. Ours is a typical case.

### Case Report

A 10-year-old girl was referred to the Cleveland Clinic because of swelling of the right knee of approximately two months' duration. At the time of the examination, the patient had difficulty going up stairs and was unable to squat.

Positive physical findings were confined to the supracondylar area of the right knee which was 1½ inches larger than the left. The area was also firm, tender, and showed some increase in temperature.

Roentgenograms were obtained, which showed a lytic and sclerotic lesion in the distal third of the right femur, and a diagnosis of osteosarcoma was made radiographically (Fig. 1). Laboratory values were within normal limits except for serum alkaline phosphatase which was 30.2 units.

The patient was admitted to the hospital and a biopsy of the lytic area in the distal third of the right femur was performed, confirming the diagnosis of osteosarcoma.

Approximately three months after onset of symptoms, the patient received cobalt therapy to the entire right femur. A total of 6800-rads tumor dose was given over a 39-day period. The treatment was well tolerated and she was discharged.

Approximately 4½ months after onset of symptoms, the patient was seen again. This time



FIG. 1. Initial lesion shown in metaphysis of right distal femur. There is irregular osteoblastic activity with bone production noted in soft tissue; there is also evidence of a Codman's triangle proximally on lateral side.

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Submitted May 7, 1973.



there were sclerotic lesions in the proximal left humerus, the right distal femur, and a pulmonary mass was also suspected. Roentgenograms obtained a month later confirmed these and also showed other sites of involvement, including the left acetabulum; the left greater trochanter; the left distal femoral, proximal tibial and fibular metaphyses; the right proximal tibial epiphysis; and the right proximal and distal tibial and fibular metaphyses (Figs. 2-5).

The patient was remarkably asymptomatic from the multiple lesions and was treated conservatively. She died at home approximately six months after onset of symptoms.

### Discussion

Multiple osteosarcomas have been known to arise in bones which have already undergone disease, such as in Paget's disease of bone or in

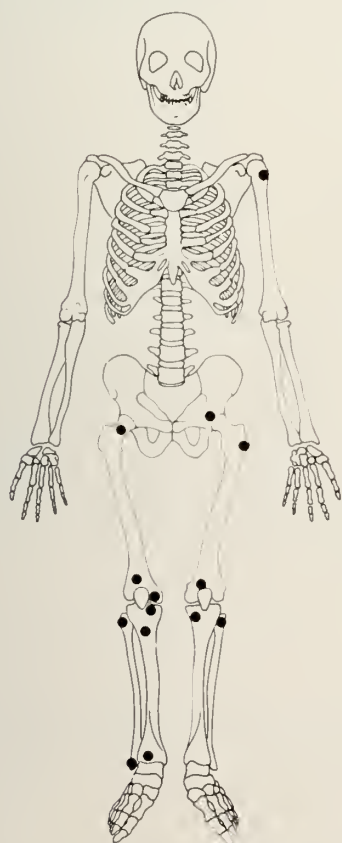


FIG. 2. Other sites of blastic activity shown in skeletal drawing include metaphysis of left humerus, left acetabulum, right femoral neck, left greater trochanter, left distal femoral, proximal tibial and fibular metaphysis; right proximal tibial epiphysis and right proximal and distal tibial and fibular metaphyses. Eventually there was also marked involvement of the right distal femoral epiphysis from local extension.

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individuals who have been exposed to radium. It has also been well documented that osteosarcomas metastasize to bone. However, the widespread nature which is manifested in this and other cases certainly makes the possibility of a multicentric origin plausible.<sup>1-3</sup>

Usually the patients with this disease are between 5 and 17 years of age. The radiographic findings are usually those of sclerotic lesions which, on histologic examination, show an increased number of osteoblasts along with multiple bizarre nuclei and tumor osteoid and bone formation.<sup>4</sup> Epiphyseal as well as metaphyseal areas of bone have been involved, and the expected life span in most of these patients is approximately six months. It is important at least to be aware of the possi-



FIG. 3. Osteoblastic metastases involving distal right tibia and fibula.



FIG. 4. Osteoblastic metastases involving left distal femur and proximal tibia.



FIG. 5. Metastasis involving left proximal humerus.

bility of multiple bone involvement by osteosarcoma. At the time of biopsy, a long-bone skeletal roentgenologic survey should be performed in order to rule out other possible lesions, thereby preventing unnecessary radiation if multifocal areas are demonstrated.

#### Summary

A 10-year-old girl with pathologically proven osteosarcoma of the right distal femur subsequently was shown to have multiple sclerotic osseous lesions. A long-bone roentgenologic survey should be performed in cases of osteosarcoma in order to

exclude multifocal involvement in which radiation therapy would not be of value.

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## Discussion of E.N.T. Case of the Month

(continued from p. 829)

These lesions have a characteristic appearance of squamous papillomas, a benign exophytic lesion commonly seen in the upper respiratory tract. Histologic examination of these growths will reveal a thick, well-differentiated epithelium with an underlying fibrous stroma.

Squamous papillomas may be effectively treated by simple excision, with cauterization of the base of the lesion using silver nitrate, phenol, or an electric spark.

Although these lesions have a typical clinical appearance, the excised tissue should always be sent for histologic evaluation.



# Anaplastic Lung Cancer with Metastases

## Case Report of a 15-Year Survival

LEONARD B. GREENTREE, M.D.

A COMPUTERIZED data evaluation of spontaneous regression of cancer in 224 patients reported upon in the medical literature concludes that an infection superimposed on a neoplasm may be related to the spontaneous regression of cancer; that infection can possibly enhance the host's natural resistance against cancer!<sup>1</sup> The following case report of a 74-year-old patient, living and well 15 years after a preoperative infection and postoperative empyema following lung resection for metastatic, anaplastic, bronchogenic carcinoma, supports this conclusion.

### Case Report

A 59-year-old white farmer was admitted to The Ohio State University Hospitals on November 11, 1957. His chief complaints were a persistent cough of several months duration, progressive weakness, and a weight loss of 5.4 kg (12 lb). The cough had increased in severity with moderate sputum production. Hemoptysis had occurred only once. Three weeks prior to this admission, he developed a chill, fever, and "flu" symptoms. These subsided except for the persisting cough. Chest films of this well-developed, well-nourished, anxious patient showed a large, well-delineated mass in the posterior segment of the upper lobe of the right lung extending into the hilum. Preoperative bronchoscopy on November 14, 1957 showed no gross evidence of a tumor, but bronchial aspirations were reported to contain nests of malignant cells. Right pneumonectomy and mediastinal lymphadenectomy was performed on November 18, 1957. Examination of the chest at surgery showed a large cystic tumor occupying a large portion of the right upper lobe of the lung with metastatic lymph nodes in the hilar structures. It was not possible to do a right upper lobectomy because the neoplasm had extended into the lower lobe. The pathologist reported a poorly differentiated, squamous-cell carcinoma of the bronchus with extensive spread of the neoplasm through the bronchial wall into the lung parenchyma. (See figure.) Extensive necrosis of the tumor mass was noted along with metastatic involvement of a parabronchial lymph node. This patient was included in the U.S. Public Health Service Study of adjuvant chemotherapy and received 6 mg nitrogen mustard intrapleurally at the time of the operation, 6 mg intravenously on the day of the operation, and also on the first two postoperative days for a total of 24 mg of nitrogen mustard. He was discharged from the hospital on November 27,

### The Author

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1957. Discharge diagnosis was poorly differentiated bronchogenic carcinoma of the right lung with lymph node metastasis. Discharge prognosis was guarded because of the metastasis to the lymph nodes.

This patient was readmitted to University Hospital one month later for an oleothorax which was being done at that time to fill up the post-pneumonectomy space; 1200 cc of sterile olive oil was injected into the right pleural cavity. He was discharged two days later with no problems being encountered. He was readmitted three days later as an emergency. He was found to have an infected oleothorax with a spiking temperature of 38.9°C to 39.4°C. The pleural space was drained of the infected olive oil. Culture of this fluid yielded gram-positive cocci and *staphylococcus aureus* sensitive to penicillin, erythromycin, and chloramphenicol. Treatment consisted of intrapleural injections of penicillin, intrapleural irrigations with Chlorpactin solutions, and parenteral penicillin and streptomycin. The patient was discharged from the hospital 21 days later greatly improved. He went home to his rocking chair on the farm expecting to die. He did not. About a year later, he was treated with electroshock therapy for a psychotic depression reaction. He recovered from this too. After sitting at home for about five years, he finally decided he was cured and went back to work. A letter received from him in February 1972 states that his general health is good and that he is working everyday and has been doing so for the past nine years. One year later, a neighbor reports that this patient, now 74 years of age, is living and well 15 years after being treated for a metastatic, anaplastic, bronchogenic carcinoma complicated by a postoperative empyema.

### Discussion

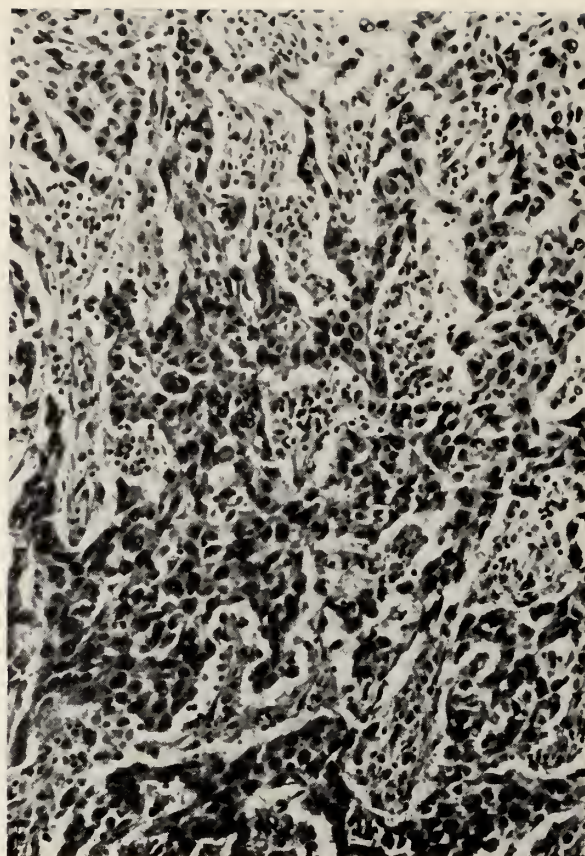
This case report of a prolonged survival from lung cancer after pneumonectomy, which was complicated both by a preoperative infection and postoperative empyema brings to mind the first successful pneumonectomy for cancer of the lung.<sup>2</sup>

This was performed by Dr. Evarts A. Graham nearly 40 years ago. The patient, a physician, suffered repeated attacks of cough and fever for a period of seven months prior to surgery. The patient recovered and survived over 30 years after a stormy postoperative course complicated by empyema. In review of this case report of a 74-year-old patient, living and well 15 years after a preoperative cough and fever and postoperative empyema following a pneumonectomy for a metastatic, poorly differentiated, lung cancer, several salient features can be discussed.

Patients with neoplasms such as this one, despite surgery, chemotherapy, or radiation, usually live no longer than one year, seldom over several years. While there are statistical reports which for the most part indicate that postoperative empyema enhances the host's natural resistance to bronchogenic carcinoma, this case report offers a reasonable clue as to why the prolonged survival did occur. Postoperative empyema complicating 192 lung resections for bronchogenic carcinoma at the Roswell Park Memorial Institute resulted in a 54 percent five-year survival rate as against only a 27 percent rate in the noninfected cases, a 100 percent increase!<sup>3</sup> Impressive too are the results reported by Ruckdeschel and his co-workers.<sup>4</sup> In their study, postoperative empyema complicating 489 surgically resected lung cancers resulted in a 50 percent five-year survival rate as against only 18 percent in the noninfected cases. Sensenig<sup>5</sup> reports an even higher five-year survival rate of 57 percent in patients having surgically resected lung cancers and who suffered a postoperative empyema. LeRoux's results were still higher, 66 percent. Contrariwise, the Thoracic Surgical Service at the Memorial Hospital<sup>7</sup> failed to reveal any increase in their five-year survival rate when postoperative empyema complicated surgery for bronchogenic cancer, it being only 13 percent. They did, however, attach statistical significance to the increased incidence of staphylococcal and hemolytic streptococcal infections in their long-term survivors. They believe these organisms may possibly be related to enhanced host resistance factors.

Interesting too, though not on lung cancer, is the impact of postoperative infection on colon and rectal carcinoma. Postoperative peritonitis complicating bowel surgery on 2009 patients with colon and rectal surgery at the University of Iowa Hospital resulted in a 55 percent five-year survival rate as against only a 39 percent survival rate in the noninfected cases. This comparison rate becomes even more impressive when it is noted that almost one half of the patients with peritonitis died in the hospital after surgery.<sup>8</sup>

The host's anamnestic immune response to an infectious agent may well be the clue to cancer remission in this case. It is reasonable to conjecture that this patient's attack of chills, fever, and "flu"



Poorly differentiated squamous cell carcinoma, bronchus, with extensive spread through bronchial wall.

symptoms, which appeared about three weeks prior to his first hospital admission for lung surgery and chemotherapy followed by postoperative empyema, may be the prime reason contributing to this 15-year cancer remission. If we do not as yet fully understand the nature of cancer, we can formulate a working hypothesis that the presence of an infection immediately prior to and during conventional cancer therapy improves the chances for prolonged cancer remission.

Despite abundant experimental evidence accumulated over the past few years, our understanding of the true nature of immunity and cancer is still highly speculative. The direction of research in immunology and cancer is now toward molecular biology with DNA and RNA being the charismatic symbols of our times. All suspected causes of cancer: viral, mutational, or regulatory failure, now center on cell genetics and on nucleic structure and function with the small lymphocyte of the reticuloendothelial system appearing to play an important role both in cellular immunity and in the body's natural defenses against cancer.

Although the control of disease is a very complex matter with many factors at play, one cannot



ignore the impact of host resistance and cellular immunity on cancer. Immunology and cancer need not await the final answer of molecular biology. The future emphasis on enhancing the host's natural resistance to cancer by nonspecific stimulation of the reticuloendothelial system may prove to be a far more promising approach to preventing and curing cancer than the present methods of treating this disease. Surgery alone is successful only for localized tumors. Radiation is lethal to both normal and neoplastic cells. Cancer chemotherapy as used today is not specific enough to kill only malignant cells, and even this is powerless against the survival of a drug-resistant mutant. Unfortunately, too, these chemotherapeutic agents are immunosuppressive. They paralyze the host's resistance. When they reduce the cancer to what ought to be manageable size, the patient's defenses are no longer able to cope with it. For these obvious reasons, the need for methods to stimulate and reinforce the host's immune defenses against cancer becomes urgent. Obviously, owing to the danger, one cannot consider doing a clinical trial of induced empyema with resectable lung cancer. Since statistical significance has been attached to the increased incidence of staphylococcal and streptococcal infections in the long-term survivors of lung cancer, the use of attenuated live vaccines made from these bacteria may prove to be an important nontoxic method of boosting the host's natural defenses against cancer. Interestingly enough, staphylococcal and hemolytic streptococcal bacteria were isolated from nasal and throat swabs taken from this patient on March 1, 1973.

If this hypothesis is correct, attenuated live staphylococcal and hemolytic streptococcal bacterial vaccines can be a valuable, safe adjunct to cancer surgery, radiation, and chemotherapy. In these vaccines, the bacteria are still living organisms, but with their infectivity and toxicity reduced to completely safe levels by passaging them from one animal to another or from one culture to another for many generations. Vaccine is given to the patient prior to and during cancer therapy and then at prescribed intervals to maintain an increased, sustained resistance against cancer.

It was Duran-Reynals<sup>9</sup> who stated: "Cancer control will be achieved by immunological methods. Cynics may delay the day—but sooner or later, we shall prevent cancer with vaccines, and

cure them with vaccines, antisera, and other measures which strengthen natural resistance."

### Summary

A patient with a poorly differentiated bronchogenic carcinoma with hilar lymph node metastases is presented as a case report. It is conjectured that a preoperative infection followed by a postoperative empyema with its anamnestic immune reaction played a role in the prolonged survival in this patient; that it may be a prime reason why this patient is living and well 15 years after a lung resection and chemotherapy for lung cancer. Since one cannot consider doing a clinical trial of induced preoperative infection and postoperative empyema, and since statistical significance is attached to the presence of staphylococcal and hemolytic streptococcal bacteria in this patient and other long-term survivors of bronchogenic carcinoma, the preoperative and postoperative use of attenuated live staphylococcal and streptococcal bacterial vaccines may prove to be a safe, valuable adjunct to cancer surgery, radiation, and chemotherapy in prolonging cancer survival.

**Acknowledgment:** The author appreciates the assistance of the personnel in the Department of Pathology, The Ohio State University Hospitals.

**Generic and Trade Name of Drug**  
Sodium oxychlorosene—Chlorpactin WCS-90  
(Guardian Chemical Corp)

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# Azotemia

LEONARD B. BERMAN, M.D.\*

THE FAMILIAR WORD "AZOTEMIA" refers to an accumulation of nonprotein in the blood, the major forms of which are urea and creatinine. The physiologic differences between these two are significant and we can take advantage of this by measuring the concentration of both. The key fact is that creatinine is formed *in constant amounts* from skeletal muscle metabolism and is excreted almost entirely by glomerular filtration. Urea, on the other hand, is made in the liver *in proportion to the amount of protein being catabolized*. Its excretion by the kidney is a composite of glomerular filtration rate, tubular re-absorption, and urine flow.

American usage dictates that blood urea be expressed as blood urea nitrogen (BUN). The concentration of the latter in normal blood is about 10 mg per 100 ml. The normal creatinine concentration is 1 mg per 100 ml. Therefore we begin with a normal ratio of ten to one. It is from this ratio that we may appreciate certain clinical problems. Imagine three patients with the following values indicated:

| Patient | BUN<br>mg/100 ml | Creatinine<br>mg/100 ml | $\frac{BUN}{Creatinine}$ |
|---------|------------------|-------------------------|--------------------------|
| A       | 100              | 10                      | 10                       |
| B       | 100              | 2                       | 50                       |
| C       | 50               | 10                      | 5                        |

*Interpretation:* Patient A has a creatinine of 10 mg per 100 ml and, therefore, has renal failure which may be acute or chronic. The BUN is proportionally elevated to 100 mg per 100 ml, suggesting no added abnormalities of urea production. Patient B, on the other hand, has a very different set of findings. The

creatinine of 2 mg per 100 ml indicates a mild impairment of renal function. The BUN of 100 with a ratio of 50 suggests a large increase in protein catabolism. The most common, but not the only, cause for this is gastrointestinal bleeding. One litre of whole blood contains nearly 200 grams of protein. This kind of load suddenly exposed to digestive enzymes produces a large amount of urea. The slight impairment of filtration rate (which is a consequence of gastrointestinal bleeding) impairs the ability of the kidneys to excrete the urea load with the resulting chemistries as shown. The situation of patient C is different. The creatinine of 10 again indicates renal failure. The failure of BUN to rise proportionately, indicates one of two possibilities. First, there has been removal of urea by dialysis treatment. The alternative explanation is that the protein catabolism has been decreased, eg, by a special diet used in renal failure. These diets are often very low in protein content. The failure of the liver to make urea is an extremely rare event and may be ignored.

Other examples of an abnormal ratio are found in clinical practice. The use of tetracycline is an illustration of a drug which increases protein catabolism. In the presence of normal renal function, the increased urea may be excreted by the kidneys without noticeable elevation of the BUN. Tetracycline *in the presence of impaired renal function* may produce a set of numbers resembling those of patient B. Urea production by the liver goes on unimpaired even in the presence of liver disease such as cirrhosis or hepatitis. Therefore, a patient with both liver and kidney failure generally has the chemistries depicted in patient A.

It is clear from the foregoing examples that the clinician may better interpret clinical events by the simultaneous use of BUN and creatinine. In these days of automated blood chemistries, it is worth doing routinely.

\*Dr. Berman is Chief of the Department of Nephrology, Mt. Sinai Hospital of Cleveland. Submitted July 26, 1973.



# Professional Activities



## Roundup of Medical-Health Legislation in the Ohio General Assembly

By DAVID RADER  
Legislative News Editor

THE FIRST SESSION of the 110th General Assembly (1973) was marked by a lessening of activity in the area of medical and health legislation. This is not necessarily negative, since poor legislation can be far more harmful than none at all.

The House and Senate are being led by different parties and there are many freshman legislators who are attempting to learn the legislative process, resulting in a decrease in total volume this year. Altogether, there were 1,414 bills introduced—412 Senate and 1,002 House. Of these, only 207 passed.

Legislators who played an important part in health legislation this year included Senator Clara E. Weisenborn (R-Dayton) who served as Chairman of the Senate Education and Health Committee. Senator Weisenborn sponsored S.B. 206, to update state assistances to TB patients, and was instrumental in seeing that other health issues maintained steady progress in the Senate. She is to be congratulated for hard work and her perseverance.

Members of the House who were involved with health legislation include Representatives Phale D. Hale (D-Columbus), Leonard Camera (D-Lorain), and Richard Celeste (D-Cleveland). Representative Hale served as Chairman of the House Health and Welfare Committee. Representative Camera sponsored H.B. 168, to require that proper emergency medical authorization forms be used by all Ohio public schools.

Representative Celeste sponsored H.B. 467 which requires the Ohio Department of Public Welfare to make interim payments to Medicaid providers. Any Medicaid provider who received over \$4,000 during either 1971 or 1972 may be eligible for a one-time interim payment if the Welfare Department is currently behind on that providers payments. A mailing on this subject has been sent to all OSMA members from the Headquarters Office.

One act of major interest to OSMA members is H.B. 417, Camera (D-Lorain). This new law will require that all employers place all employees under the state workmen's compensation policy. Previously, employers with two or less employees were exempt. This new law covers not only office employees but domestic help as well (if that help is paid more than \$50 per calendar quarter). OSMA members should be careful to comply with this new, broader workmen's compensation law.

Of primary significance to physicians is Am. Sub. S.B. 1, Aronoff (R-Cincinnati), which reduces legal age of majority from 21 to 18 years of age. Its effective date is November 21, 1973. James Pohlman, OSMA legal counsel, is analyzing this new statute with regard to its effect on the physician-patient relationship. His comments will be published in a forthcoming issue of the *Ohio State Medical Journal*.

Another bill that will have a major effect on Ohio physicians is S.B. 209, Jackson (D-Cleveland). This bill, which will become effective

December 19, 1973, will require a prenatal test for gonorrhea to be included at the same time as the current prenatal test for syphilis. These tests, to be approved by the Ohio Department of Health, are to be made without charge by the Department if requested by the physician. The tests may be waived by the local health commissioner if it is contrary to the patient's religious beliefs.

Here is a list of additional bills that passed the General Assembly this year, together with the effective date of each, if available (some of these bills had not yet been signed into law by the Governor at press time).

**Am. Sub. S.B. 52**, Cook (R-Toledo), increases unemployment compensation benefits.

**Am. S.B. 72**, Stockdale (R-Kent), provides for creation of Northeastern Ohio Universities College of Medicine. Effective November 23, 1973.

**Am. S.B. 160**, Applegate (D-Steubenville), establishes hemophilia program in the Department of Health.

**Am. S.B. 176**, Jackson (D-Cleveland), permits sick leave to be used for pregnancy. Effective November 22, 1973.

**Am. S.B. 206**, Weisenborn (R-Dayton), requires state financial assistance for treatment of tuberculosis patients. Effective November 16, 1973.

**Am. S.B. 209**, Jackson (D-Cleveland), provides standard prenatal testing for gonorrhea. Effective December 19, 1973.

**Am. S.B. 218**, Secrest (D-Cambridge), changes the official designation of Civil Defense Section of the Adjutant General's Department of Disaster Services Agency.

**Sub. S.B. 232**, Valiquette (D-Toledo), creates the Ohio State Cancer Agency. Effective November 21, 1973.

**Am. S.B. 322**, Calabrese (D-Cleveland), revises law licensing nursing home administration.

**Am. S.B. 363**, Aronoff (R-Cincinnati), permits reimbursement under insurance policies for dental work.

**H.B. 3**, Baumann (D-Columbus), exempts ostomy appliances and accessories from sales tax. Effective November 21, 1973.

**Am. Sub. H.B. 86**, Shoemaker (D-Bourneville), makes appropriation for the biennium. Effective June 29, 1973. (Three items vetoed).

**Am. Sub. H.B. 168**, Camera (D-Lorain), requires school districts to distribute and file emergency medical authorization forms. Effective August 22, 1973.

**Am. Sub. H.B. 243**, Lehman (D-Cleveland), invalidates use of cognovit note. Effective November 20, 1973.

**Am. Sub. H.B. 341**, Celebrezze (D-Cleveland), certifies school nurses and permits them to perform additional duties and services. Effective November 21, 1973.

**Am. Sub. H.B. 384**, Mallory (D-Cincinnati), creates a Department of Affairs of the Elderly. Effective November 23, 1973.

**Am. Sub. H.B. 417**, Camera (D-Lorain), increases workmen's compensation benefits. Effective November 16, 1973. (Certain provisions effective January 1, 1974; other provisions effective July 1, 1974).

**Am. Sub. H.B. 467**, Celeste (D-Cleveland), authorizes emergency interim payments to providers of health care to the indigent. Effective August 22, 1973.

**Am. Sub. H.B. 586**, Lehman (D-Cleveland), requires medical insurance coverage for psychological treatment. Effective November 22, 1973.

Bills that did not pass this session but that will be held over until the 1974 session include the following:

**S.B. 212**, Ocasek (D-Akron), establishes a separate chiropractic licensing board. This has been strongly opposed by the OSMA.

**S.B. 149**, Jackson (D-Cleveland), requires the state to contract with a fiscal intermediary to administer the Medicaid program.

**S.B. 378**, Weisenborn (R-Dayton), requires an ophthalmologist to certify an eye examination prior for contact lenses.

**H.B. 34**, Fiocca (D-Akron), requires a premarital rubella test.

**H.B. 202**, Bowers (D-Steubenville), requires use of auto safety belts.

**H.B. 397**, Kopp (D-Columbus), licenses immunohematologists.

**H.B. 410**, J. Sweeney (D-Cleveland), places a lay person on each state licensing board.

**H.B. 420**, Mastics (R-Cleveland), omnibus drug abuse law.

**H.B. 474**, Hale (D-Columbus), requires Departments of Family Practice and Family Practice residency programs in state supported medical schools.

**H.B. 790**, Netzley (R-Laura), registers physicians assistants.

**H.B. 825**, Speck (R-New Concord), establishes a medical school loan commission.

**H.B. 827**, Bowers (D-Steubenville), redefines limited branches of medicine.

**H.B. 846**, Batchelder (R-Medina), protect medical diagnosis from being held as fraud.

**H.B. 943**, Wittenberg (D-Toledo), to require nursing home improvements.

**H.B. 989**, Wilkowski (D-Toledo), establishes new abortion procedures.



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Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

## **Triaminic® Expectorant with Codeine ©**

**Each teaspoonful (5 ml.) contains:**

Codeine phosphate, 10 mg. (Warning: May be habit forming); Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

Triaminic Expectorant with Codeine is a Schedule V controlled substance.

**The Adult Expectorants that are great for kids, too.**



## National and Local Broadcast Series Will Feature 'Prevention'

November 19 marks the premiere of an important series of five one-a-month television programs to be presented on Public Broadcasting stations across the country every fourth Monday evening. Subjects of the series are: Heart Disease (Nov. 19); Inborn Genetic Defects (Dec. 17); Pulmonary Disease (Jan. 14); Trauma (Feb. 11); and Cancer (March 11).

Designed to inform the public about methods of prevention, early detection and treatment of the five medical conditions that account for three out of four deaths in the United States, it is also planned as a springboard for community action. Many of the PBS stations will schedule additional local programming (to coordinate with the national presentation) by featuring local medical leaders and community follow-up activities.

Cosponsoring the series are numerous medical,

health education, labor, public service, fraternal and other types of organizations including the American Medical Association.

Among Public Broadcasting Service stations in Ohio participating in the series are the following: WOUB, Channel 20, Athens; WOET, Ch. 45, Dayton; WBGU, Ch. 70, Bowling Green; WCET, Ch. 48, Cincinnati; WVIZ, Ch. 25, Cleveland; WOSU, Ch. 34, Columbus; WGSF, Ch. 31, Newark; WMUB, Ch. 14, Oxford; and WGTE, Ch. 30, Toledo.

Dr. F. J. L. Blasingame, has joined the Chicago-based firm of Systema, Incorporated, as director of medical affairs. The company specializes in performance learning systems for a wide range of clients in general industry, as well as in the health field. Dr. Blasingame's responsibilities will include consulting services to the health care industry. For 11 years he was executive vice-president of the American Medical Association, and in recent years published a newsletter entitled "Medical News Report."

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

## APATHY • IRRITABILITY FORGETFULNESS • CONFUSION



## Cerebro- Nicin<sup>®</sup> CAPSULES

**A GENTLE CEREBRAL  
STIMULANT & VASODILATOR  
FOR GERIATRIC PATIENTS**

**CEREBRO-NICIN<sup>®</sup> double-blind study\***  
shows how some senile symptoms can be treated.  
Four times as many aging patients showed  
striking improvement.

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Pentylentetrazole .....100 mg. • Nicotinic Acid ...100 mg.  
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.  
L-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.  
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.

**AVAILABLE:** Bottles 100, 500, 1000

**SIDE EFFECTS:** Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

**INDICATIONS:** As a cerebral stimulant and vasodilator.

**RECOMMENDED GERIATRIC DOSAGE:** One capsule three times daily adjusted to the individual patient.

**WARNING:** Overdosage may cause muscle tremor and convulsions.

**CONTRAINDICATIONS:** Epilepsy or low convulsive threshold.  
**CAUTION:** Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .

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\*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

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# The irritations of man's day are often reflected in his gut.

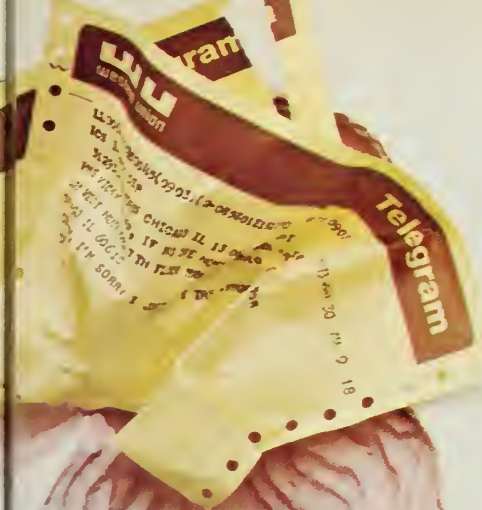
The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.





**IMPORTANT INFORMATION:** This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

**Indications:** Lomotil is effective as adjunctive therapy in the management of diarrhea.

**Contraindications:** In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

**Warnings:** Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

**Usage in pregnancy:** Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

**Precautions:** Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

**Adverse reactions:** Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

**Dosage and administration:** Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

**Overdosage:** Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

**Dosage forms:** Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

# Lomotil®

## TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:  
diphenoxylate hydrochloride . . . 2.5 mg.  
(Warning: May be habit forming)  
atropine sulfate . . . . . 0.025 mg.

takes care of the gut issue  
in irritable colon

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## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 305432



## Give us her nights.

Prescribe Placidyl. Chances are, we'll give her a good night's sleep.

Insomnia is often suffered by the elderly. Anxiety and agitation might be the cause. Or the effect. In time that can be determined. But tonight one fact is painfully clear: she needs sleep.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

## Placidyl®



(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)



# Outstanding Exhibits Recognized at 1973 OSMA Annual Meeting

THE OHIO STATE Medical Association Annual Meeting held in Columbus, May 6-9, 1973 included among its features Scientific, Health Education, and Technical Exhibits.

A judging committee selected several exhibits as outstanding and the sponsors were presented certificates of recognition as well as permanent type plaques to be displayed in their respective booths and kept as permanent mementos.

A summary of exhibits selected as outstanding appeared in the July issue of *The Journal*. More details on some of these exhibits was published in the September and October numbers. Here is additional information on some of the outstanding presentations.

## Exhibit on Therapy in Appendicitis Is Honored

Honorable Mention in the Field of Original Investigation was given to the exhibit entitled "Selection of Initial Antibiotic Therapy in Appendicitis with Rupture or Abscess," sponsored by the following physicians, all associated with the staff of Miami Valley Hospital Dayton: Sidney Miller, M.D., Rudolf Hofmann, M.D., Frederick A. Hillis, M.D., and Robert K. Finley, M.D.

The material presented in the exhibit was described as follows:

In appendicitis with rupture or abscess, the selection of an antibiotic regimen for initial therapy must usually be made without benefit of culture and antibiotic susceptibility data. It commonly consists of multiple antibiotics (often two or more) whose combined spectra seem likely to be effective against the potential pathogen(s). However, in many cases the choice includes at least one antibiotic of possible serious toxicity.

This report presented data from a retrospective study of 100 patients which suggest a more rational basis for selection of initial antibiotic therapy.

From these observations a regimen consisting of a class of broad-spectrum antibiotics of relatively low toxicity was devised and evaluated in a prospective study of 30 patients. In the prospective study, 80 percent had a satisfactory response to a

regimen of cephalothin and cephaloridine. The average hospital stay was 11.9 days.

The data of both studies indicate that the use of multiple unrelated antibiotics offers no advantage over the single antibiotic regimen.

## Trigeminal Neuralgia Exhibit Honored

The exhibit entitled "Trigeminal Neuralgia—A New Approach to Surgical Treatment," was designated by the judging committee to receive Honorable Mention in the Field of Original Investigation. Sponsors were John M. Tew, Jr., M.D., and Frank H. Mayfield, M.D., of the Departments of Neurosurgery, Good Samaritan and The Christ Hospitals, Cincinnati.

The sponsors have described the procedure, called "Percutaneous Electrocoagulation of the Trigeminal Nerve," as follows:

During the past five years a new technique has come to the attention of medical practitioners interested in the treatment of trigeminal neuralgia (tic douloureux). This procedure offers a safe effective means for achieving longstanding relief of this dreaded condition. Although Tegretol and other related drugs have provided a gratifying addition to our medical treatment, it has been learned that many patients do not tolerate these drugs or fail to obtain satisfactory relief. It is the purpose of this exhibit to review the technique, physiological basis, and results obtained with this procedure in 130 patients.

The physiological basis of this technique lies in the premise that the pain of trigeminal neuralgia is conducted through the thinly myelinated fibers of the trigeminal nerve. It is known that these fibers are more sensitive to heat than those larger and more heavily myelinated fibers of the motor root and sensory nerve conducting touch reception. Therefore, an insulated needle is inserted into the trigeminal cistern among the rootlets of the trigeminal nerve; electrical stimulation permits precise localization in the desired area of the rootlets responsible for the painful phenomenon. With the correct frequency of stimulation and intensity we are frequently able to precisely reproduce the pain experienced during a paroxysm of





1972-1973 OSMA President William R. Schultz holds the plaque for the Special Award presented to sponsors of the Medical Advances Institute exhibits, in the field of health education. The sign reads, "Medical Advances Institute—PSRO—the How, What & Why in Ohio—The Dept. of Preventive Medicine, OSU College of Medicine."

tic douloureux. Armed with this information and anatomical localization, the patient is briefly anesthetized with a short-acting barbiturate which is administered intravenously. Precise control of such a current by temperature monitoring produces a uniform thermal lesion. The end result is analgesia; that is, complete loss of discrimination of pin prick in the area of the radiated pain, but preservation of touch and the muscle power necessary for mastication.

In our experience with more than 130 cases it has been possible to achieve relief of pain in 100 percent of the individuals. The recurrence rate of 8 to 10 percent has been acceptable since it is very simple to repeat the coagulation procedure. We have been able to achieve relief of pain in all patients despite the occasional necessity of repeating the coagulation prior to discharge from the hospital.

The acceptance of this procedure by the patients has been uniformly good and the undesirable side effects are few in number. They consist of disagreeable sensory changes in the face 5 percent; difficulty in chewing 7 percent; diminution of

sensation of cornea 20 percent; and corneal ulceration 2 percent; and temporal diplopia 2 percent.

In conclusion, we feel that this procedure provides a safe and effective method for the relief of trigeminal neuralgia.

## Honorable Mention Goes to Exhibit on Cytology

Honorable Mention in the Teaching Field was accorded the exhibit entitled "Extragenital Cytology," sponsored and presented by the following team from the Department of Pathology, Ohio State University College of Medicine, Columbus: Emmerich von Haam, M.D., Kathryn Skitarelic, M.D., Norman Malik, M.D. Mary Snyder, C.T. (ASCP, IAC), Susan Chappel, C.T. (ASCP), Susan Wilson, C.T. (ASCP), and Evelyn Walker, secretary.

The material presented by the exhibit has been described as follows:

While cytologic evaluation of vaginal smears is an accepted technique, similar evaluation of material from extragenital sites is not generally as

well known. The study of effusions, urine, sputum, material obtained at bronchoscopy, needle aspirations, and GI tract material are important in the diagnostic evaluation of a patient. These specimens can be readily examined by cytologic methods. Definitive diagnoses can be made as criteria for malignancy are well established.

The exhibit presented graphically to the clinician the diagnostic potential of cytologic study of material from sites other than the female genital tract. This was done by means of 5 x 7 color transparencies mounted in back-lighted cases. The following categories were included in the display: Breast aspirations, urine, oral cavity, gastrointestinal tract, respiratory tract, and effusions.

In addition to the color pictures of the diagnostic cytologic material, a brief description of the method for obtaining and preparing each type of specimen and statistics on the diagnostic accuracy also was included.

For those interested in a more detailed description of the specimen collection procedure a handout was available at the exhibit booth. Anyone interested in this handout at this time may obtain one by writing to the following address: Department of Clinical Cytology, Room 734, Ohio State University Hospital, 410 West 10th Avenue, Columbus, Ohio 43210.

## Ohio Exhibit Wins AMA High Award

An Ohio exhibit that won top honors at the 1972 OSMA Annual Meeting in Cincinnati went on to the American Medical Association in New York City this year and won top honors there also.

The exhibit, "Know Your Eyes—Anterior Segment Eye Diseases," was presented at the 1972 OSMA Annual Meeting in Cincinnati and won the Gold Award in the Teaching Field. It was sponsored by Ira A. Abrahamson, Sr., M.D., Ira A. Abrahamson, Jr., M.D., and Leonard Jacobson, M.D., of Cincinnati.

At the AMA Convention in New York City in June, the exhibit received the first award for the Outstanding Scientific Exhibit of the AMA meeting by the American Academy of Family Physicians, as well as receiving the Certificate of Merit award for the best ophthalmological exhibit.

The Cincinnati team has won numerous honors for their eye exhibits compiled from a whole library of case reports accumulated over a period of years.

# impotence

is driving them apart

## Android®-25 Tablets

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Methyltestosterone N.F. — 25, 10, 5 mg.

**For the treatment of impotence due to androgenic deficiency in the male.**

**DESCRIPTION:** Methyltestosterone is 17β-Hydroxy-17-Methylendrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgenic deficiency. 3. Impotence due to androgenic deficiency. 4. Postpubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of cli-

macteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be dis-

continued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.



# Leading Scores Announced at Ohio Physician-Golfers Tournament

TOP HONORS WERE garnered by Robert E. Barkett, M.D., Mansfield, in the Ohio State Medical Golfers Association's 1973 Tournament June 7 at Canton's beautiful Brookside Country Club. Dr. Barkett carded a low gross 77 as nearly 150 physician-golfers battled the long and exacting Brookside course, made even more demanding by tough pin emplacements, treacherous rough and "no-roll" fairways resulting from heavy rains June 6.

Thomas R. Leech, M.D., Lima, carded an 80-11-69 for overall low net honors.

Dr. Barkett was playing in the age 39-and-under flight, Dr. Leech in the 49-and-under flight.

Receiving a standing ovation for his low gross in the 79-and-over age group, at the awards ban-

quet that evening, was Richard P. Bell, M.D., Lakewood, who will be 86 years old in September. Dr. Bell won the OSMGA tournament in 1933 and saw his son, David M. Bell, M.D., win the tournament twice in the 1960's.

Flight honors were as follows:

## 39-and-under:

Jerry A. Wensinger, M.D., Marion, low gross (81)

Ralph R. Ballanger, M.D., Columbus, low net (82-2-80)

## 49-and-under:

Aris W. Franklin, M.D., Akron, low gross (82)

Robert C. Hastedt, M.D., Dover, low net (94-19-75)

## 59-and-under:

John C. Stahler, M.D., Dayton, low gross (82)

Henry W. Brown, M.D., Cleveland Heights, low net (84-11-73)

## 69-and-under:

Maurice F. Lieber, M.D., Canton, low gross (87)

Harold C. Marsico, M.D., Lorain, low net (95-18-77)

## 79-and-under:

James R. Moorehead, M.D., Columbiana, low gross (98)

F. T. Gallagher, M.D., Rocky River, low net (98-12-86).

The Ohio State Medical Golfers Association was organized in 1920. Current President is C. J. Shames, M.D., Mansfield. Serving on the Board of Directors with Dr. Shames are Dr. David Bell, Dr. Stahler, Donald W. English, M.D., Lima; James S. Greetham, M.D., Marion; John A. Kramer, M.D., Ada; Edward A. Sawan, M.D., Akron, and Edwin R. Zartman, M.D., Columbus.

The tournament consisted of 18 holes of stroke play, with a buffet luncheon "on the turn." An early evening hospitality hour was followed by the awards banquet. Special trophies and prizes were awarded the overall low gross and low net champions. Engraved silver bowls were awarded the flight winners.



Robert E. Barkett, M.D., Mansfield, is shown with the first place trophy he won by taking top honors among nearly 150 physicians competing in the Ohio State Medical Golfers Association's 1973 tournament at Canton's Brookside Country Club June 7. He shot a 77 on a rain-soaked course.





Richard P. Bell, M.D., Lakewood, 86 years old this September, displays the silver bowl he won for low gross honors in his age flight at the OSMA outing. Dr. Bell won the tournament in 1933.



Ohio State Medical Golfers President C. J. Shames, M.D., Mansfield, prepares to present trophies and other prizes at the banquet following the OSMA Tournament June 7.



This foursome has played together annually in the OSMGA tournament for 20 years. Shown just before they tee off at the June 7 outing are (left to right) Drs. Edward B. Young and W. E. Yingling, both of Lima, and Drs. John E. Hendricks and William M. Wells, both of Newark. Dr. Wells is Secretary-Treasurer of the Ohio State Medical Assn.

**"BUT MY FEW DOLLARS  
WON'T MAKE ANY  
DIFFERENCE!"**



Thankfully not everybody says that. We of OMPAC know different. Your dues, added to mine, and to everybody else's dues, can make a difference. Politics is everybody's business, and nationalized medicine would be tragic. But, maybe you would rather work for the government? If not, join OMPAC in 1974 . . . and invite a friend to join.

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**OHIO MEDICAL POLITICAL ACTION COMMITTEE**

Box 5617, Columbus, Ohio 43221

Your dues of \$25.00 make you a member of the American Medical Political Action Committee (AMPAC) as well as of OMPAC.

Send your dues to your County Medical Society secretary-treasurer who will forward them to Columbus. The OMPAC office will forward AMPAC dues to Chicago.

A copy of our report, filed with the appropriate supervisory officer is (or will be) available for purchase from the Superintendent of Documents, United States Government Printing Office, Washington, D. C. 20402.



# Obituaries

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**Alfred Harold Berr, M.D.**, Cleveland; Western Reserve University School of Medicine, 1903; aged 92; died September 18; general practitioner for many years in Cleveland; veteran of World War I.

**Jackson Blair, M.D.**, Cleveland; Western Reserve University School of Medicine, 1919; aged 79; died September 1; member of OSMA and AMA; practitioner of long standing in Cleveland, engaging in general practice and occupational medicine.

**Francis John Denning, M.D.**, Steubenville; Loyola University Stritch School of Medicine, 1936; aged 65; died September 17; member of OSMA and AMA; general practitioner in the Steubenville area since 1938; veteran of World War II.

**John Holmes Dingle, M.D.**, Cleveland; Harvard Medical School, 1939; aged 64; died September 15; diplomate of the American Board of Preventive Medicine and associated with numerous professional societies, especially in the field of clinical investigation; chairman for many years of the Department of Preventive Medicine at Case Western Reserve University; internationally known for his work in the field of infectious diseases and recipient of numerous awards; veteran of World War II.

**Carl Albert Dreyer, M.D.**, Toledo; Temple University School of Medicine, 1932; aged 70; died September 1; member of OSMA and AMA; practitioner of long standing in Toledo, engaging in general practice, general surgery and obstetrics.

**Wilder Prince Ellis, M.D.**, Wooster; Western Reserve University School of Medicine, 1914; aged 86; died September 27; member of OSMA and AMA; associated with the Presbyterian Mission Board from about 1918 to 1938, with service principally in Persia; private practitioner in Mt. Eaton and in Shreve; from 1952, medical director for the College of Wooster.

**Hazen Leonard Hauman, M.D.**, Toledo; University of Michigan Medical School, 1933; aged 67; died September 18; member of OSMA and the AMA; Fellow, International College of Surgeons and the American College of Surgeons; diplomate, American Board of Surgery; practicing

surgeon for many years in Toledo and recently medical director of the extended care facility of the Toledo Health and Retiree Center; veteran of World War II.

**Paul Irwin Hoxworth, M.D.**, Cincinnati; Ohio State University College of Medicine, 1934; aged 66; died September 12; member of OSMA, AMA, American Surgical Association, and Society for Surgery of the Alimentary Tract; Fellow, American College of Surgeons; diplomate, American Board of Surgery; practitioner of long standing in Cincinnati and professor of surgery at University of Cincinnati.

**John Daniel LeFevre, M.D.**, Springfield; Jefferson Medical College of Philadelphia, 1937; aged 62; died September 8; member of OSMA and AMA; practitioner in Springfield since 1939, specializing in internal medicine; past president of the Clark County Medical Society; veteran of World War II.

**Elza M. Madernieks, M.D.**, Macedonia; medical degree from University of Latvia, 1924; aged 73; died August 3; member of the medical staff at Hawthornden State Hospital. She came to the U. S. about 1949 and joined the hospital staff in 1960 after practicing in South Dakota.

**Hazelett Andrew Moore, M.D.**, Oxford; University of Cincinnati College of Medicine, 1915; aged 83; died September 24; member of OSMA, AMA and American Academy of Family Physicians; general practitioner of long standing in the Oxford area; medical director of the Western College, Oxford; one of the founders of the Butler County Mental Health Association.

**Howard Samuel Myers, M.D.**, Massillon; Western Reserve University School of Medicine, 1915; aged 86; died September 24; former member of OSMA; practitioner at Navarre until 1926 and since that time in the Massillon area; former Massillon health commissioner; veteran of World War I.

**Edgar Clark Pickard, M.D.**, Cuyahoga Falls; Ohio State University College of Medicine, 1925; aged 73; died September 24; member of OSMA, AMA, and American Rheumatism Association; practitioner of long standing in the Cuyahoga Falls area and in recent years a member of the

medical staff of Kent State University; veteran of World War II.

**Dan Olin Ratzloff, M.D.,** Parma; University of Kansas School of Medicine, 1940; aged 64; died September 18; member of OSMA, AMA, American Society of Abdominal Surgeons and the American Geriatrics Society; Fellow, American College of Obstetricians and Gynecologists; diplomate, American Board of Obstetrics and Gynecology; practitioner in the Parma area since 1946; served in the U. S. Navy Medical Corps during World War II.

**Aladar Revesz, M.D.,** Cleveland; medical degree from the University at Budapest, Hungary, 1911; aged 88; died September 12; resident of the Cleveland area since 1960; practitioner for many years in his native Hungary, and later in Israel.

**Joseph Alexander Ring, M.D.,** Berea; Western Reserve University School of Medicine, 1957; aged 41; died September 7; member of OSMA, AMA, and American Academy of Ophthalmology and Otolaryngology; diplomate, American Board of Ophthalmology; practitioner in Berea since 1961. Among survivors are his father, Dr. Homer E. Ring, and brother, Dr. Thomas L. Ring, both of Bellaire.

**Thomas Clifford Sharkey, M.D.,** Hillsboro; St. Louis University School of Medicine, 1956;

aged 41; died August 29 while on a vacation trip in Georgia; member of OSMA and AMA; Fellow, American College of Surgeons; diplomate, American Board of Surgery; practicing surgeon in the Hillsboro area for about ten years; served in the Air Force Medical Corps, 1957-1959.

**Charles Francis Shonk, M.D.,** Logan; Ohio State University College of Medicine, 1922; aged 76; died September 20; member of OSMA and AMA; practitioner for more than 50 years with virtually all of his professional career served in the Logan area.

**James Cloudsley Walker, M.D.,** Dayton; University of Virginia Medical School, 1914; aged 83; died September 2; member of OSMA, AMA, Clinical Orthopaedic Society and American Academy of Orthopaedic Surgeons; Fellow, American College of Surgeons; diplomate, American Board of Orthopaedic Surgery; practicing surgeon in Dayton from 1921 to 1968 when he retired; served in the Army Medical Corps immediately following World War I; in 1955 named to a medical all-American team of football greats by *Spectrum*.

**Lloyd Herbert Werley, M.D.,** Canton; University of Pittsburgh School of Medicine, 1926; aged 76; died September 15; member of OSMA and AMA; practitioner of long standing in the Canton area, specializing in internal medicine.

★

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# EXHIBITS

Scientific  
Exhibits  
Wanted

## 1974 Annual Meeting, Ohio State Medical Association

**DO YOU HAVE AN EXHIBIT** or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1974 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Sheraton-Cleveland Hotel, 24 Public Square, Cleveland, Ohio. Exhibit Days and Times will be as follows: Monday, May 13 — 5:30 P.M. - 8:00 P.M.; Tuesday, May 14 — 9:00 A.M. - 4:30 P.M. and Wednesday, May 15 — 9:00 A.M. - 4:30 P.M.

Mail applications to the attention of J. E. Tetirick, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 17 South High Street, Suite 500 Columbus, Ohio 43215.

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### APPLICATION FOR SPACE SCIENTIFIC EXHIBITS

## 1974 Annual Meeting, Ohio State Medical Association

**Sheraton-Cleveland Hotel, Cleveland, May 13, 14 and 15**

\_\_\_\_ I am interested in receiving an application and details regarding space for a scientific exhibit at the 1974 OSMA Annual Meeting. Please send to:

Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

AS WE APPROACH the warm and festive Thanksgiving Holiday, it seems a fitting time to offer grateful thanks yet again to the doctors of America for their skills, their dedication, and their efforts. It would also seem a fitting time—yet again—to thank them for permitting us, the Auxiliary, to help serve their profession.

## International Health

The Auxiliary has, through its many and varied activities, a tremendous opportunity for service. One that we don't write about nearly as much as we should is that of International Health. Under the skillful and compassionate supervision of Mrs. Howard E. Smith, of Toledo, this is a blessed opportunity to help the world's unfortunate, maimed and ill persons and to extend hospitality and friendship to our world neighbors.

Mrs. Smith emphasizes these four interest areas in advising local Auxiliaries how to participate:

1. Think I.H.A. Build bridges of basic understanding for world events.
2. Provide agency assistance such as Project HOPE, SKIP (scholarship for kids of international physicians), collecting and sending pharmaceutical supplies to needy agencies.
3. Hospitality on the home front such as welcome kits for the newcomer, local interest events, tutoring, home hospitality, and personal sharing of hobbies and holidays.
4. Friendship over there. Service of doctors and other medical personnel to deprived areas overseas, pen-pals, medical periodicals and appropriate books.

"This is our opportunity to show that we truly care and that we wish to share" says Carolinea Smith.

That seems a wonderful goal to reemphasize at Thanksgiving time, wouldn't you say?

## What Is "IT"?

Its cover page is inviting and colorful. Its inside pages are informative and helpful. What is IT? The invaluable Auxiliary workbook compiled for State Board members, county presidents and presidents-elect, and in effect for all county chairmen to consult. This annual workbook is a remarkably comprehensive and effective presentation of data which is of tremendous help to the various officers and chairmen in the performance of their duties during the year.

Important information is under one cover—virtually at the fingertips when needed. It is, in a sense, the Auxiliary bible. Each chairman presents her "own case." Here's a bird's-eye view of some of those "cases":

## AMA-ERF

Chairman—Mrs. Henry Holden

Treasurer—Mrs. H. R. Hunt

The AMA-ERF programs for the 1973-74 Auxiliary year will be to continue support of the Student Loan Guarantee Funds and funds for medical schools.

Your Auxiliary may raise funds to support these programs in any way that is agreeable with your Auxiliary and Medical Society. Remember to

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## THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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### President

Mrs. Karl Ulicny  
864 Highland Ave.  
Salem, 44460

### President-Elect

Mrs. S. J. Glueck  
3405 Kappel Dr.  
Springfield, 45503

### Past President

Mrs. Louis Loria  
Box 331, R.D. 1  
Bristolville, 44402

### First Vice-President

Mrs. Howard E. Smith  
2144 Fordway Dr.  
Toledo, 43606

### Second Vice-President

Mrs. Henry Holden  
2459 Fifth Ave.  
Youngstown, 44505

### Third Vice-President

Mrs. Albert May  
655 Fairhaven Ave.  
Marion, 43302

### Recording Secretary

Mrs. Paul Chrenka  
22425 Westchester Rd.  
Cleveland, 44122

### Corresponding Secretary

Mrs. Carl F. Goll  
1001 Granard Pkwy  
Steubenville, 43952

### Treasurer

Mrs. William Myers  
560 Lawnwood Ct.  
Circleville, 43113



receive credit for your county and state Auxiliary all monies must be sent through the AMA-ERF Auxiliary Fund. Please inform your members and their husbands that all monies they send goes directly to the school or fund they designate. Please be sure to send me your name, address and telephone number.

Remember the following:

1. Start your records for AMA-ERF June 1, 1973.
2. Print or type legibly county, names, address, school or Loan Guarantee Fund on your contribution forms.
3. Send contribution forms with monies promptly. Banks do not have to honor checks over 30 days old. The donor is very unhappy when his check is held for 90 days or more.
4. Should you have to hold checks, it would be desirable to have a separate checking account for AMA-ERF. In this way the donations can be recorded, deposited and the canceled checks returned to the doctor promptly. Please do not hold checks longer than two weeks.
5. Send monies to your State Treasurer, Mrs. H. R. Hunt or Mrs. Henry Holden, state chairman.
6. Send an acknowledgement card or note to the contributor promptly—always remember to say “thank you.”
7. Send all inquiries for material, etc. to the Chairman, Mrs. Henry Holden.
8. Be sure to endorse commission checks from the sale of Christmas cards before sending the check to the treasurer.
9. The AMA-ERF fiscal year ends May 31, 1974. All contributions must reach the Chicago

office by midnight, May 25, 1974, to be counted on the 73-74 contributions for Ohio, so please send all monies to Bonnie Hunt by May 20, 1974 so that she may have them in Chicago by the deadline of May 31st.

a. Our report must be in to State by April 30th, so please send all forms and reports to us by April 20th, so we can give the awards out at State Convention in May.

10. Please do not hesitate to ask for help or ideas, or to pass on your thoughts or projects. We are only as far as your telephone and will be happy to help in any way at all.

Good Luck! We are looking forward to hearing from you soon, and to meeting with you at the Workshop where we will learn and grow together.

A RE-RUN of Some of the “Old Goodies” and a List of Some New Fund Raising Ideas for Your Local AMA-ERF Auxiliary Projects.

1. A new line of AMA-ERF postcards is available at no cost from the AMA office. They are available in four colors in packages of 25 from:

Mrs. Helen Mazur, AMA-ERF  
535 North Dearborn St.  
Chicago, Illinois 60610

2. New: Party-Pac of table cloths and napkins. These can be used year round. This pac is made exclusively for AMA-ERF. Bargain price with a good profit for your county of 40 percent or 40 cents of each dollar goes to AMA-ERF. Write to: I. B. Byers, c/o American Linen Supply Co., Paper Products Division, 700 Industrial Boulevard, N.E., Minneapolis, Minn. 55413.

3. NEW: Another brand new Fund Raiser is “HOLLY” for the holidays. I have the informa-

The ideal gift for colleagues . . . patients . . . nurses . . . your friends and family.

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tion for this so you can get started on it early and have your orders back in time for the holiday.

4. And, of course, the old stand bys:

- |                                 |            |
|---------------------------------|------------|
| Christmas Cards                 | Teas       |
| Playing Cards                   | Stationery |
| Luncheons                       | Memorials  |
| In Honor Cards                  | Dances     |
| Fashion Shows                   | Bazaars    |
| Thinking of You Cards           |            |
| Note Paper & Memo Pads from AMA |            |

Nutrition

Chairman: Mrs. Robert E. Krone

Physical fitness is dependent upon a sound body properly nourished, adequate exercise, sufficient rest, a good mental outlook. The National Auxiliary has provided a number of "package programs" to assist us in teaching individuals responsibility for maintaining good health. Prevention is well worth "a pound of cure."

The Nutrition Education Package Program emphasizes the training of doctors' wives in nutrition so that they may volunteer as assistants in various feeding programs. It provides sources of nutrition information, promotional aids, curriculum suggestions and lists of agencies or persons already involved in nutrition education programs.

Consider these two points:

1. Are your own members well informed about nutrition? Are you and your family properly nourished? Over-fed? Actually undernourished in the face of abundance?
2. What groups in your community need your help? There are both education and action programs in day care centers, programs for feeding the elderly, school lunch programs, poverty programs, etc.

Here is a partial bibliography of reliable materials. Write me directly for help with more specific areas.

Deutsch, Ronald, *The Family Guide to Better Food and Better Health*. Meredith Corporation, Des Moines, Iowa, 1971 \$7.95

Ewart, Charles D., *How to Enjoy Eating Without Committing Suicide*. Nutrition Information, Inc., Arlington Hts., Ill. 1972 \$2.00

*Family Fare: A Guide to Good Nutrition*. USDA H & G Bulletin #1. Supt. of Documents, U.S. Govt. Prtg. Office, Washington, D.C. (45¢)

McWilliams, M. *Nutrition for the Growing Years*, Wiley, 1967.

Leverton, Ruth M., *Food Becomes You*. Garden City, N.Y., Dolphin Books, Doubleday & Co. 1965.

Martin, E. A., *Nutrition in Action*. Connally and Brown, 1971.

Mayer, Jean: *Overweight: Causes, Cost, Control*. New Jersey, Prentice Hall, 1968.

*Mealtime Manual for the Aged and Handicapped*, Institute of Rehab., N.Y.U. Medical Center, Simon & Schuster, 1970.

Stare, F. J., M.D., *Eating for Good Health*. New York. Cornerstone Library, 1969. \$1.45

White, Philip, M.D., *Let's Talk About Food*. AMA, 535 N. Dearborn St., Chicago, Ill. \$1.00

Wyden, Peter, *The Overweight Society*, New York. Wm. Morrow Co. 1965.

Health Manpower

Chairman: Mrs. Ernest L. Fox

Most successful Auxiliary projects, including those on Health Manpower, are ongoing and

Jack L. Ratner  
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You're invited to a business built on love

... to be spectacular with your holiday shopping. Amaze and please her with a cluster of emeralds, a jade bracelet, an important diamond. You know women have a thing about being loved, and nothing says "I love you" like fine jewelry. In my confidential, comfortable "Suite 1015" salon (17 South High, Columbus), see a remarkable collection. Look, handle, learn—with no obligation. Prices? Quite modest for such quality, thanks to direct resources, long experience, minimum expenses. For your convenience, appointments help: call collect 614/224-3377.



planned for long range so you will be repeating your useful programs. However, because various phases of medical care and social services are being questioned and advances are constantly being made we must keep up-to-date with the changing attitudes and manpower requirements. We, associated with medicine, should be leaders in getting adequate and accurate information to the public about manpower functions, training and needs. Do your Health Manpower activities do this?

### WHAT CAN YOU DO? BE A PROMOTER!!!

What do you Promote?

1. Information about education or training in all the health fields from the college oriented to on-job trained for pay or volunteer positions.

2. How the various health fields are used in health care—prevention, treatment, rehabilitation or research.

3. Where these people are needed—rural and less advantaged city areas as well as those shown in the usual TV series.

Where do you direct this Promotion?

1. To students in schools at any level you can reach but especially middle as well as high school. Remember:

a. High school prerequisites are needed for many careers.

b. Interest is keen in younger students and they can set goals to work for.

c. Science and health teachers, school nurses and counselors are helpful in reaching them as well as parents through PTA's or other groups.

2. To those in group c above. They need information to assist students.

3. To scouts, church or health oriented volunteer groups or other clubs. Many groups are looking for programs or projects.

a. These may be students interested in information about health careers.

b. They can also be adults looking for a career or retired persons seeking something to do.

c. Information can be slanted toward volunteer as well as paid positions or just to get Health Manpower information into the community.

What kind of programs do you Promote? (Skip those your Auxiliary is already doing but look carefully if you need a program or a different emphasis on an exciting project)

1. Career Days, Fairs, seminars and panel programs for any of the above groups. Yours wasn't a success!!! What went wrong?

a. Did you go it alone or work with allied fields, hospitals or other organizations

such as the Hospital Assoc., Red Cross, etc.

b. Attendance too small? Maybe it wasn't if those attending were really interested. Also a good program advertises itself—don't stop at one try.

c. Too expensive or too few workers? Maybe you went overboard or didn't really "plug" it. How about a regional program with other counties?

2. Slide or movie programs. Many are available from many sources. Consider purchase of one or more or make your own so it is always available.

3. Sponsor Health Career Clubs in schools or other organizations with active participation by your members rather than in name only.

4. Volunteer programs — either teenage or adult.

a. Start one if none exists. (Relieve a career worker for other things.)

b. Work with existing ones by supplying training or educational programs or by recruiting personnel.

5. Arrange or help with visits or tours of various health facilities.

6. Scholarships.

a. Give either by loan or outright.

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b. Furnish information on those available be it local or otherwise.

7. Form an information center for any or all kinds of Health Manpower resources. Do you know how many students (and even parents) don't know how to go about getting information or how to use it when they do?

8. Establish a good working relationship with local publicity media—press, radio, and TV—feed them information about manpower programs, spot announcements, etc.

9. Put information at public disposal in doctors' offices, schools, libraries, hospitals or other effective places.

The list could go on reaching as far as your imagination and ingenuity. Invoice your community resources whether you are a small or large Auxiliary.

### Worth Thinking About

Here is a quotation from the workbook that says it succinctly and impressively:

"The only ideas that will ever work are the ones you put to work; not dream about."

## Outlook Much Brighter for New Family Practitioners

Family practice, a new medical specialty which came into being less than five years ago, is beginning to show tangible results in terms of producing more family doctors, according to a recent survey report of the American Academy of Family Physicians.

A total of 413 family physicians have graduated from approved family practice residency programs, the survey conducted by the Education Division of the AAFP shows. Following behind are 1,771 family practice residents in training programs across the country, an increase of 756 over last year.

Of the 1,771 residents, 756 are in the first year of training. There are 653 second-year residents, and 354 entering their third year. The survey also shows that 86 percent of the available first-year positions are filled.

A recent meeting of the joint AMA-AAFP Residency Review Committee for Family Practice resulted in the approval of 10 programs, bringing the total number of approved residency programs to 173, an addition of 40 programs in the last year.

## National Institutes of Health Interested in Referrals

The clinical center of the National Institutes of Health at Bethesda, Md., is accepting a limited number of patients each month for study and therapy. Patients are admitted only on referral by a physician or dentist.

The National Institutes of Health is the research arm of the Department of Health, Education, and Welfare and is concerned specifically with basic laboratory investigations and research in several fields.

A pamphlet has been revised and updated to give in more detail the referral service of the center. It is DHEW Publication No. (NIH 73-217).

Inquiries and referrals should be addressed to the Office of the Director, The Clinical Center, National Institutes of Health, Bethesda, Md. 20014.

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The Catholic Medical Mission Board, 10 West 17th Street, New York 10011, reported that in September it shipped medical and hospital supplies valued at more than \$22,000 wholesale to Chile following the political conflict in that country.

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Owens-Illinois, Inc. has announced a gift of \$300,000 to the Medical College of Ohio at Toledo Foundation in memory of Raymon H. Mulford, former chairman of the company's board of directors, who died last February 9. The Foundation, development arm of the Medical College, intends to use the funds to help purchase some 40 acres of land near the college's new campus.

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The Maternal and Child Health Program of the University of California School of Public Health, Berkeley, Calif. 94720 has announced its postgraduate programs for physicians. These programs lead to the degree of Master of Public Health. The announcement stated that applications are being accepted for September 1974.



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Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products and let them know that you see their advertising in *The Journal*.

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Rates: 50 cents per line. Minimum charge \$1.00 for each insertion. Display classified, \$1.00 per line. (9 lines to the inch) Prices cover the cost of remailing answers. Forms close the 8th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal  
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

**FIFTY-YEAR OLD DOCTOR**, recently recovered from nervous breakdown, seeks residency of any sort, preferably internal medicine, or pathology. Reply Box 694, c/o Ohio State Medical Journal.

**PHYSICIAN'S OFFICE FOR RENT** in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio, Phone 271-0291.

**IMMEDIATE OPENING** for Ob-Gyn, Internal Medicine and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; progressive community with excellent educational system including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

**ASSOCIATES WANTED:** Cincinnati based professional corporation seeks full or part-time associates. Openings available in Emergency rooms, community clinics, or Industrial Medical Centers. Medical Health Services, Inc., 5902 Robison Rd., Cincinnati, Ohio 45213. Phone: 513/631-0200.

**ADMINISTRATOR** — On a requirement satisfying part-time basis for an ethnic home for the aged with limited nursing facilities. Reply Box 695 c/o Ohio State Medical Journal.

**INTERNISTS, FAMILY PHYSICIANS:** Position available on Health Care Teams of physicians and dentists providing family care to inner-city residents of Cleveland. Neighborhood Health Center well organized to allow physicians to provide the best care they are capable of. Salaries competitive, liberal fringe benefits. Address inquiries to David G. Miller, M.D., Medical Director, Hough-Norwood Family Health Care Center, 1465 E. 55th St., Cleveland, Ohio 44103.

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**EMERGENCY ROOM PHYSICIAN NEEDED IMMEDIATELY**—Established group of two full time and six part time physicians need third full time man for active emergency service. Incorporated. Salary \$36,000 to \$45,000 for 40-50 hours per week, plus bonus quarterly. Excellent 300 bed general hospital in community of 45,000 only 40 miles from Columbus. Many fine specialists available for help and referral. Please contact: L. H. Miller, M.D. 614-344-0331, Newark, O.

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(Continued from Previous Page)

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**GENERAL PRACTITIONER**—Full-time staff physician needed for Domiciliary Medical Service in 858 bed general medical and surgical hospital. License in any state acceptable; salary range \$22,328 to \$29,248 per annum depending upon qualifications. Maximum leave and insurance benefits. Write: Chief of Staff, Veterans Administration Center, 4100 West Third Street, Dayton, Ohio 45428. An Equal Employment Opportunity.

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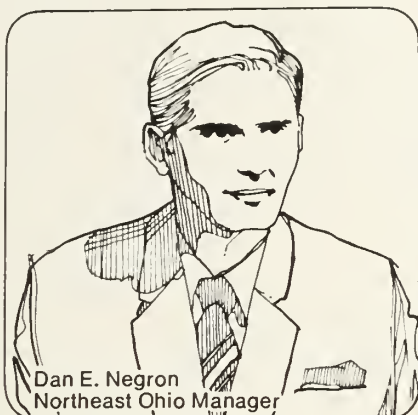
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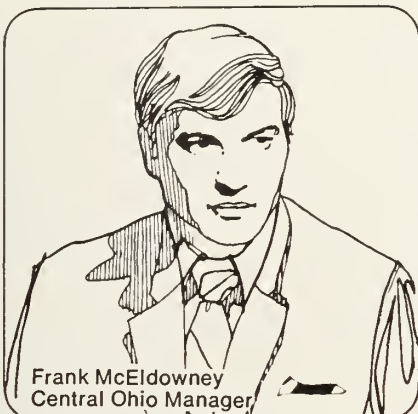




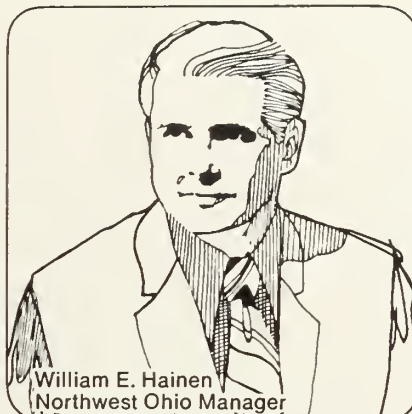
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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

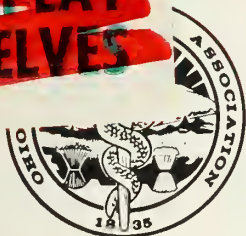
**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.



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DECEMBER • 1973  
VOL. 69 NO. 12

# *The Ohio State* MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

THE FRANCIS A. COUNTESS  
LIBRARY OF MEDICINE  
BOSTON  
13 7 DEC 1973

## **In This Issue**

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EXCHANGE OFFICE  
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Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling  
*and* the psychotropic action of Valium® (diazepam).



Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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# NOTICE TO ALL MEMBERS!

Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA* (with other AMA publications), will expire on December 31. Here's how to renew them:

Mail your dues immediately to the SECRETARY-TREASURER OF YOUR COUNTY MEDICAL SOCIETY.

OSMA dues are \$65.00. AMA membership dues are \$110.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer. Ohio Medical Political Action Committee-American Medical Political Action Committee dues are \$25. OMPAC-AMPAC dues are recommended.

**Life Active membership**—a new category of membership approved by the 1973 House of Delegates. This membership is available to 500 physicians who make a single, lifetime dues payment of \$1,250.00. When this payment is made, the life active physician is assured a full, active lifetime OSMA membership, subject only to maintenance of Ohio license and adherence to the *Principles of Medical Ethics*.

Many members probably will want to send one check to cover local, state, national, and OMPAC-AMPAC dues. **Make Check Payable To Your County Medical Society.**

Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago.

Your local Secretary-Treasurer will forward your OMPAC-AMPAC dues to OMPAC Headquarters.

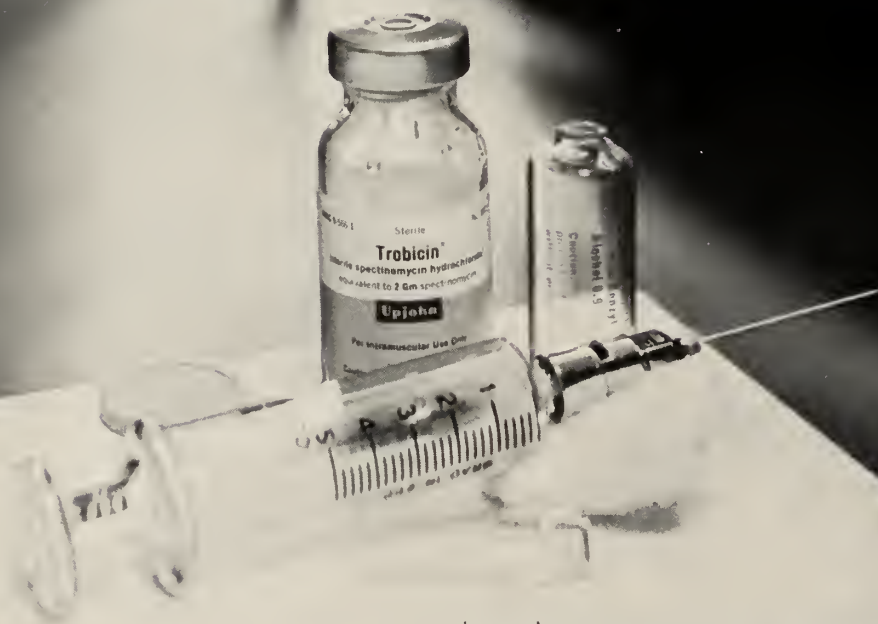
As a part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal* and copies of the *OSMAgram*, without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA*, *Today's Health*, and the *American Medical News*.

The member who becomes eligible for exemption from dues, and wishes to take advantage of exemption, should make his wishes known to the secretary-treasurer of his County Medical Society. After exemption has once been established, the member is automatically carried over from year to year, unless the status changes.

# acute gonorrhea

This patient  
just received  
an effective, private,  
physician-controlled  
treatment.

It took just one short visit...



\*Urethritis, cervicitis, proctitis when due  
to susceptible strains of *N. gonorrhoeae*



### **Trobicin—The advantage of injectable therapy.**

Once Trobicin is injected, treatment is usually complete; there can be no problems with patients sharing, skimping, skipping or forgetting medication.

### **Trobicin—The aspect of privacy.**

There are no prescriptions to fill, no capsules to take. Neither family, friends nor co-workers need know or suspect the patient's problem.

### **Trobicin—Indication and dosage.**

Spectinomycin is indicated only for use in acute urethritis and proctitis in the male and acute cervicitis and/or proctitis in the female when due to susceptible strains of *N. gonorrhoeae*. The usual dosage for Trobicin in adult males is 2 grams intramuscularly<sup>†</sup>; 4 grams intramuscularly in females.

### **Trobicin—Not effective for syphilis.**

Trobicin is not effective for any stage of syphilis. Trobicin may mask or delay the symptoms of incubating syphilis. If concurrent syphilis is suspected, follow the patient serologically for at least 3 months. Patients with syphilis should receive adequate specific anti-syphilitic therapy with an appropriate antibiotic. Trobicin is contraindicated in patients previously found hypersensitive to it.

Intramuscular

# ...and **Trobicin**<sup>®</sup> 2 gm and 4 gm vials sterile spectinomycin hydrochloride

#### **Sterile Trobicin**

*Sterile Trobicin (spectinomycin hydrochloride)*  
—For Intramuscular Injection:

2 gm vials containing 5 ml when reconstituted with diluent

4 gm vials containing 10 ml when reconstituted with diluent

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin.

**Indications:** Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

**Contraindications:** Contraindicated in patients previously found hypersensitive to spectinomycin.

**Warnings:** Not indicated for the treatment of syphilis. Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of

syphilis is suspected.

*Safety for use in infants, children and pregnant women has not been established.*

**Precautions:** The usual precautions should be observed with otropic individuals. During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hemocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

**Adverse reactions:** The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia. During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hemocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single- and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

**Dosage and administration:** Keep at 25° C and use within 24 hours after reconstitution with diluent.

**Male—Inject 5 ml intramuscularly for a 2 gram dose.** Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

**Female—Inject 10 ml intramuscularly for a 4 gram dose.**

**How supplied:** Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of 400 mg spectinomycin per ml (as the hydrochloride). For intramuscular use only. **Susceptibility Powder**—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

**Caution:** Federal law prohibits dispensing without prescription.

*For additional product information see your Upjohn representative or consult the package insert.*

**Upjohn**

The Upjohn Company, Kalamazoo, Michigan 49001

MED B-5-S (MBR-1)

<sup>†</sup>For patients with gonorrheal proctitis and for patients in geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams is preferred.



Editor's Note: The following letter is in response to the questionnaire published on page 793 of the October issue, warning readers that the Food and Drug Administration may remove some 480 drugs from the market.

October 19, 1973

Ohio State Medical Journal

Dear Sirs:

In addition to filling out my questionnaire, I would like to editorialize on what seems to be happening in the FDA.

As a family practitioner, Board certified and University trained pre-residency, I was taught and still in principle believe that drugs should generally be used separately with the doses specified for the individual needs of each patient and, therefore, not used in combination. However, my experience in private practice has changed my views not in principle but certainly in qualitative modification of the classical university oriented opinion in the matter. For instance, in hypertension, combination drugs have been proven to be superior insofar as subtoxic doses of two or more agents can achieve hypertension control whereas effective doses of any single agent may well produce side effects and do so in a larger percentage than in combination drugs.

However, the biggest area where I take issue with our classic traditional teaching on the subject has to do with the fact that we primary physicians are treating whole patients, not cases and not numbers and not diseases. In treating whole patients we often, as is well publicized, come across varying degrees of psychosomatic and psychophysiologic overlay. A classic example is a patient with upper gastrointestinal distress who has been proven not to have ulcer disease. In this case, antispasmodics and anticholinergics do provide relief for the patient but the dose in which they are given need not be titrated because there is no organic lesion. In addition, a mild tranquilizer or

sedative is an excellent adjunct to the therapy and again usually need not be titrated because the patient usually has no clear-cut anxiety reaction or depressive neurosis.

In these cases it is so much simpler to use a combination drug, such as Combid and any of a dozen of its competitors, to achieve symptomatic relief when dealing with the total human being and it is also much easier to keep the rapport with these patients by doing so. The time saved in a volume practice in prescription writing alone makes the delivery of health care more efficient, and ultimately, more economical. Also, the combination drug usually will be of lower cost because it is produced and marketed en masse.

I should appreciate this opinion being published in the Ohio State Medical Journal in Letters to the Editor.

Sincerely,  
David R. Rudy, M.D.  
Columbus

October 17, 1973

Editor  
The Ohio State Medical Journal

Sir:

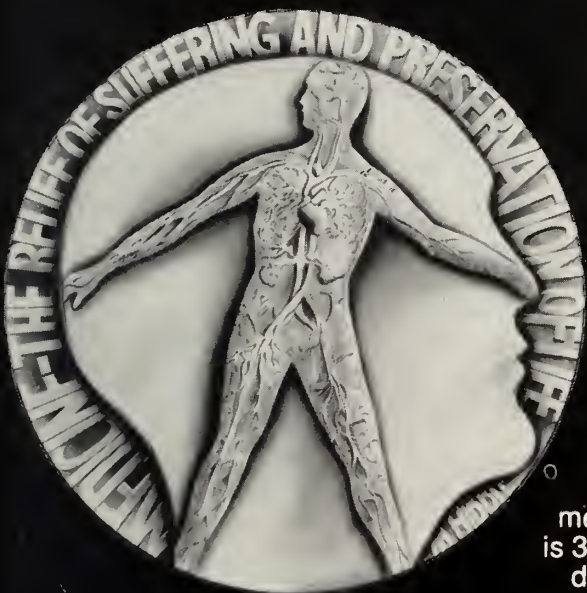
"Will Ohio Psychiatrists Improve Their Own Professional Community?" (Oct. issue of *The Journal*, page 765) The authors omit to mention that by the State of Ohio's conferring a franchise for the care of the poor upon the state hospitals the State obstructs the patient from seeking better clinical care in the open market. This embrace by the State of a clinical solution to a financial problem imposes separate but (not) equal care upon the poor. Such an administrative debacle will, if continued, do little to enlist participation of psychiatrists who are trying to encourage their patients' endeavors to exercise their own choices and judgment in the management of their patients' own lives. Improvement of the "Professional Community" will not follow upon further requirements upon patients to follow the State's money. Money must follow people!

Sincerely yours,  
Carl G. Madsen, Jr., M.D.  
Painesville

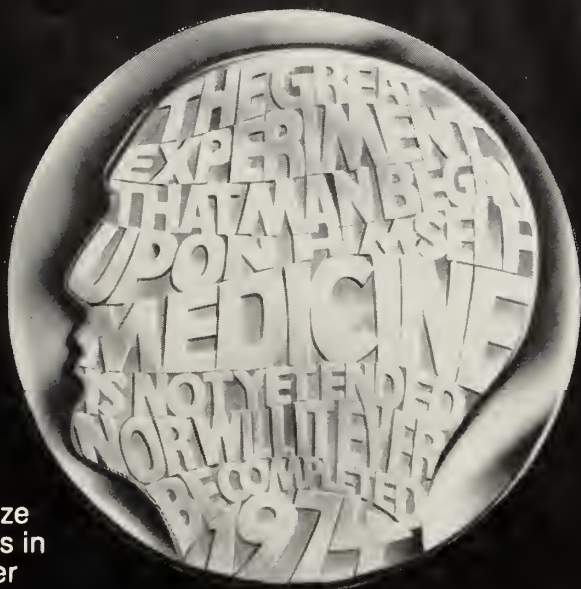


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*holiday giving. Limited to one medal per subscriber. Silver medal is \$90.00. Gold medal is \$380.00. Remittance must accompany order. Illinois residents add 5% sales tax. Prices are guaranteed until January 1, 1974 even if the price of silver and gold increases.*

## MEDICAL HERITAGE SOCIETY, LTD.

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## County Medical Society Awards Ten Scholarships

Ten scholarships were awarded at the combined dinner meeting of the Lorain County Medical Society and the Lorain County Medical Foundation, on the evening of September 11, at Elyria Country Club. The college students were guests of the Medical Society on this occasion. Established in 1963, The Foundation was created to assist Lorain County students who are preparing for careers in medicine, pharmacy, nursing, veterinary medicine, technology, and various other health-related fields. The initial funds have been periodically augmented by donations from individuals and local organizations, and one of the prime benefactors has been the Woman's Auxiliary of the Medical Society, which since 1968 has contributed approximately \$10,000 as a result of benefit projects the Auxiliary has sponsored on behalf of the Scholarship Fund.

Governed by a ten-member Board of Supervisors comprised of laymen and physicians, the Foundation utilizes income from the Trust plus other donations to award the scholarships.

This year, the scholarships were presented to students in the following categories: 1—medicine; 1—pharmacy; 6—nursing; 1—radiologic technology; and 1—medical records library science.

A total of \$3,200 was distributed. Criteria on which the Screening Committee based their selection when considering applicants earlier this year was academic performance and financial need, as well as the need for the specific skills of these professions within the area.

From 1963 to 1973 inclusive, the Medical

Foundation has awarded 97 scholarships totaling \$26,125.

President Jolin B. McCoy, M.D., introduced the Speaker of the Evening, Rev. Canon Laurence H. Hall, D.D. whose topic was "Humor—A Prescription for Living."

## Ohio Gets World's Most Powerful Laser Equipment

Equipped with the world's most powerful laser, scientists at the Columbus Laboratories of Battelle Memorial Institute are making pioneering advances in the technologies associated with controlled thermonuclear fusion energy and the generation of x-rays for new and improved uses in medical diagnosis, treatment, and research.

In the field of medical and health related research, investigators are planning:

To produce an intense and localized source of soft (slightly penetrating) and hard (deeply penetrating) x-rays that show promise in radiology as a tool for improved diagnosis and therapy;

To work on the development of experimental devices to deliver laser-generated x-rays to tissue located in otherwise inaccessible regions of the body;

To investigate the feasibility of developing an x-ray laser which would provide a valuable tool to hospitals and also to scientists conducting investigations of the genetic code.



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## acute arthritic inflammation...heat that freezes

In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

## Tandearil® helps take the heat off oxyphenbutazone NF Geigy

Tablets of 100 mg.

**Important Note:** This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasias); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

**Indications:** Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

**Contraindications:** Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

**Warnings:** Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapeutic affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against po-

tential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

**Precautions:** The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

**Adverse Reactions:** This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia,

gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals  
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# ***It's time for action to defend the laws and regulations that protect your patients against drug substitution.***

**These professional and trade organizations are united  
in supporting antisubstitution statutes and regulations:**

The American Academy of Dermatolog

The Board of Directors of the  
American Academy of Family  
Physicians

The Executive Board of the  
American Academy of Neurology

The Committee on Drugs of the  
American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the  
American College of Obstetricians  
and Gynecologists

The Board of Regents of the  
American College of Physicians

The Board of Trustees of the  
American Dental Association

The Board of Trustees of the  
American Medical Association

The American Psychiatric Association

The Executive Committee of the  
National Association of Retail  
Druggists

The Board of Directors of the  
Pharmaceutical Manufacturers  
Association

The National Wholesale Druggists'  
Association





## Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage inter-professional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that

economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

*Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D. C. 20005*





## Placidyl® (ETHCHLORVYNOL)

### Brief Summary

**Indications**—Placidyl (ethchlorvynol) is indicated as short-term hypnotic therapy in the management of insomnia.

**Contraindications**—Drug hypersensitivity and porphyria.

**Warnings**—Not recommended during the first and second trimester of pregnancy. Caution patients of possible combined exaggerated effects with alcohol, barbiturates, tranquilizers or other CNS depressants. Exaggerated effects might result in blurring of vision, paralysis of accommodation and profound hypnosis. Caution patients concerning driving a motor vehicle, operating machinery, or other hazardous operations requiring alertness after taking the drug. ADMINISTER WITH CAUTION TO PATIENTS WITH SUICIDAL TENDENCIES AND DO NOT PRESCRIBE LARGE QUANTITIES OF THE DRUG. Adjustment of the dosage of oral anticoagulants might be necessary when beginning ethchlorvynol therapy, during therapy, or after stopping therapy. This drug is not recommended for use in children. PLACIDYL HAS THE POTENTIAL FOR THE DEVELOPMENT OF PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. INSTANCES OF SEVERE WITHDRAWAL SYMPTOMS, INCLUDING CONVULSIONS AND DELIRIUM CLINICALLY SIMILAR TO THOSE SEEN WITH BARBITURATES, HAVE BEEN REPORTED IN PATIENTS TAKING REGULAR DOSES AS LOW AS 1000 MG. PER DAY OVER A PERIOD OF TIME WHEN THE DRUG WAS SUDDENLY DISCONTINUED. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED. Addiction-prone patients or those who are likely to increase dosages of the drug on their own initiative should be observed for evidence of signs or symptoms which may indicate possible early withdrawal or abstinence symptoms. Signs and symptoms associated with withdrawal and abstinence include unusual anxiety, tremor, ataxia, slurring of speech, memory loss, perceptual distortions, irritability, agitation and delirium. Other less well defined signs and symptoms, not necessarily due to withdrawal and abstinence, may include anorexia, nausea or vomiting, weakness, dizziness, sweating, muscle twitching and weight loss. Abrupt discontinuance of Placidyl following prolonged overdosage may result in convulsions and delirium.

**Precautions**—Toxic amblyopia has been reported with long-term continuous use of ethchlorvynol. Permanent visual defects have been observed, although amblyopia has improved after discontinuation of the drug. Drug dosage should be limited for elderly and debilitated patients to the smallest effective amount. If pain is present, this drug should only be given if insomnia persists after pain is controlled with analgesics. Caution is advised in prescribing the drug for patients who are being treated with either MAO inhibitors or antidepressants. Transient delirium has been reported with the combination of Placidyl and amitriptyline. Drug dosage should be reduced if prescribed for patients receiving MAO inhibitors or antidepressants. Caution should be exercised in patients with impaired hepatic or renal function. Patients who respond unpredictably to barbiturates or alcohol, or who exhibit excitement and release of inhibition in association with such agents, may also react in this way to Placidyl. Rarely, patients may exhibit symptoms suggestive of an unusual susceptibility to the drug; such as prolonged hypnosis, profound muscular weakness, excitement, hysteria, or syncope without marked hypotension. Transient giddiness or ataxia may occur.

**Adverse Reactions**—Hypotension, nausea or vomiting, gastric upset, aftertaste, blurring of vision, dizziness, facial numbness, and allergic reaction typified by urticaria have been reported following Placidyl administration. Mild "hangover" and symptoms of mild excitation have occurred in some patients. There have been rare reports of cholestatic jaundice occurring in patients taking ethchlorvynol. A few cases of thrombocytopenia have been reported in patients receiving ethchlorvynol. 304431

## Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

Insomnia may often accompany surgical convalescence. During those long nights following surgery, sleep can be as elusive as it is vital.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

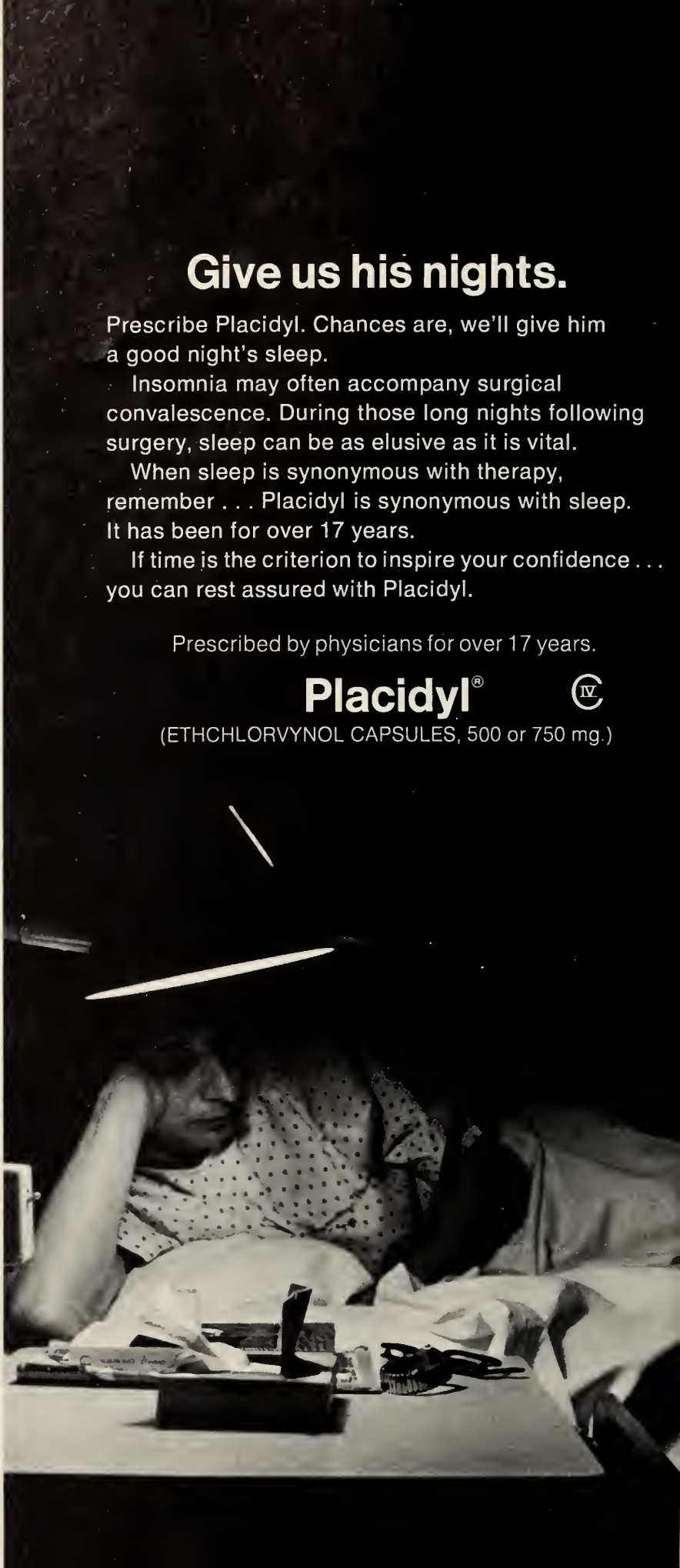
If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

## Placidyl®



(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)





## Medical Assistants Elect Ohioan as National Vice-President

Laura L. Lockhart, a certified medical assistant (CMA) from Akron, Ohio, was elected vice-president of the American Association of Medical Assistants (AAMA) at its October meeting in Washington, D.C.

The action was taken by members of the Association's policy-making House of Delegates during its 17th annual convention.

For the past 18 years Ms. Lockhart has been a medical assistant to Devitt L. Gordon, M.D., an ophthalmologist in Akron.

The new vice-president has been active in AAMA at national, state and local levels. She served as national Speaker of the House, vice-speaker and trustee for AAMA. She has also chaired and been a member on various national committees.

Miss Lockhart is a past president of the Ohio state chapter, has been District Councilor on the Board of Trustees, and assisted in organizing five new chapters in Ohio. She is a past president of the Summit, Ohio Chapter of AAMA, has served as treasurer, parliamentarian, and is a member of the Board of Directors.

The Chicago-based AAMA is a national organization of more than 15,500 medical assistants who work under direct supervision of licensed physicians. Medical assistants serve as direct links between doctors and their patients, associates and suppliers of medication and equipment. One of the major objectives of the association is to increase the education and professionalism of medical assistants.

## Medical School Enrollments Set New Record for 1973-74

The most medical schools since 1925, or 114, opened their doors for the 1973-74 school year in the United States.

The first-year entering class hit an estimated 13,790—also a new record—and total enrollment for the first time topped the 50,000 mark, with educators setting an estimate of 51,123, states the report, based on statistics compiled by the AMA's Medical Education Division.

If all senior students get a degree on schedule, there will be 11,862 new physicians at the end of the school year, the first time this figure has gone over the 11,000 mark.

First year enrollment last year was 13,726, with 47,546 the total enrollment for all classes. There were 10,391 graduates, the first time the number receiving MD degrees had topped the 10,000 mark in any one year.

There were 924 women in the 1973 graduating class and 6,099 women enrolled in all medical schools.

A continuous climb in the production of new physicians is likely. It is estimated that in 1974-75 first-year enrollments will rise to 14,336 and the number of graduates will exceed 13,000. The first-year enrollment figure will reach 15,000 for the first time with the opening of the 1976 year.

The two new schools which opened for the 1973-74 school year are Southern Illinois University School of Medicine in Springfield and the Eastern Virginia Medical School in Norfolk.

**Jack L. Ratner**  
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... when they're emeralds, amethysts, opals, diamonds or other gem materials cut from rough stone, then shaped and polished to brilliant jewels. In my confidential, leisurely "SUITE 1015" salon, look, handle and learn about my "rocks". I enjoy sharing my knowledge and 30-years experience. "SUITE 1015" of the Huntington Bank Bldg., 17 South High in Columbus is a very special place to select very special jewelry gifts. Prices? SUBSTANTIAL SAVINGS for such desirable quality thanks to direct resources and minimum expenses. For your convenience this busy time of year, call collect, 614-224-3377, for an appointment.

# Recommendations<sup>†</sup> on Combination Live Virus Vaccines

## American Academy of Pediatrics

### Committee on Infectious Diseases

In the September 15, 1971 AAP Newsletter sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."

<sup>†</sup>For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

## United States Public Health Service

### Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately."
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations)."
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."





# M-M-R<sup>\*</sup>

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials

---

M-M-R, given in a single injection, fits easily into your routine immunization program for well babies. Given at age 12 months, M-M-R provides for vaccination early in life against measles, mumps, and rubella.

| MSD suggested immunization schedule for well babies |   |
|---|---|
| Age   | Vaccine(s)  |
| 2 months  | DPT (diphtheria-pertussis-tetanus)<br>Oral poliomyelitis vaccine (triple) |
| 3 months  | DPT <sup>1</sup>  |
| 4 months  | DPT<br>Oral poliomyelitis vaccine (triple)                                |
| 6 months  | Oral poliomyelitis vaccine (triple)                                       |
| 12 MONTHS   | M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)               |

1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.  
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

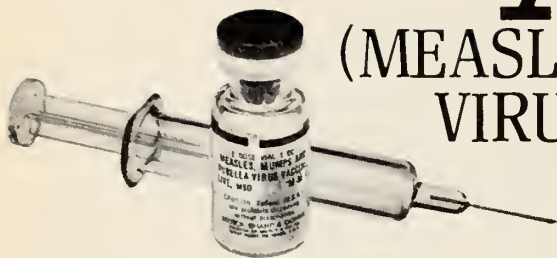
\*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

# M-M-R

## (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



**Contraindications:** Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

**Precautions:** Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines, with the exception of monovalent or trivalent poliovirus vaccine, live, oral, which may be administered simultaneously; vaccination should be deferred for at least three months following blood transfusions or administration of more than 0.02 ml immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles, mumps, and rubella vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2-8 C (35.6-46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2-8 C (35.6-46.4 F), and discard after eight hours.

**Adverse Reactions:** To date, clinical evaluation has not revealed any adverse reactions peculiar to the combination. The adverse reactions that occurred were limited to those that have been reported previously for the component vaccines.

Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101-102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have

occurred very rarely with the individual vaccines may also occur with the combined vaccine. Experience from more than 44 million doses of all live measles vaccines given in the U.S. by mid-1971 indicates that significant central nervous system reactions such as encephalitis, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered. A survey conducted in New Jersey in 1965 showed that 2.8 cases of encephalitis (of unknown cause) occurred per million children, ages 1-9 years per 30-day period." However, the Center for Disease Control has analyzed the reported reactions following measles vaccines and pointed out that "the clustering of cases in the period 6 through 13 days after inoculation as well as the recovery of measles virus (probably the vaccine strain) from the CSF of one patient does suggest that some of these cases may have been caused by the vaccine." The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis with measles (one per thousand reported cases).

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

**How Supplied:** Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID<sub>50</sub> (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 TCID<sub>50</sub> of mumps virus vaccine, live, and 1,000 TCID<sub>50</sub> of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 3/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

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Exhibits will be set up and viewed at the Sheraton-Cleveland Hotel, 24 Public Square, Cleveland, Ohio. Exhibit Days and Times will be as follows: Monday, May 13 — 5:30 P.M. - 8:00 P.M.; Tuesday, May 14 — 9:00 A.M. - 4:30 P.M. and Wednesday, May 15 — 9:00 A.M. - 4:30 P.M.

Mail applications to the attention of J. E. Tetirick, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 17 South High Street, Suite 500 Columbus, Ohio 43215.

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# Continuing Education Opportunities for Physicians in Ohio

## December

**Ohio State University College of Medicine, Continuing Medical Education Conferences;** for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

**Cardiology — December 3.**

**Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106.**

**Advances in Ophthalmology — December 5-6.**

**Workshop on Fluid and Electrolyte Clinical Problems — December 12** at Jewish Hospital, Cincinnati; and **Urology X-ray Seminar — December 13-15** at the Netherland Hilton Hotel; University of Cincinnati College of Medicine (CONMED).

**Medical Economics — Akron City Hospital, 525 E. Market St., Akron; December 19.**

**Akron City Hospital, Market & Arch Sts., Akron 44309:**

**Visiting Professor Program, Dept. of Ob-Gyn, John T. Queenan, M.D., December 5-6.**

**Medical Economics, December 19.**

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

**Courses Sponsored by Medical College of Ohio at Toledo;** for details contact MCO Office of Continuing Education, P. O. Box 6190, Toledo 43614.

**Acute Complications Related to The Pill — Clinical Seminar on Emergency Medicine —** at Blanchard Valley Hospital, Findlay, December 6, 1:00 to 5:00 p.m.

**Blood Volume: Maintenance/Replacement — Seminar on Fundamentals of Surgery —** December 1, Room G-1 at MCO, 10:00 a.m. to noon.

**Metabolic Responses to Surgery — Seminars on Fundamentals of Surgery —** December 8 and 15, 10:00 a.m. to noon, Room G-1 at MCO.

*(Continued on Page 890)*



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# Educational Opportunities in Ohio — *Continued*

## January

**Ohio State University College of Medicine, Continuing Medical Education Conferences;** for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

**Ear, Nose and Throat Disorders** — Jan. 31, at Stouffer's University Inn, 3025 Olen-tangy River Road.

**University of Cincinnati College of Medicine (CONMED):**

**Second Annual Esophagus Symposium** — at Jewish Hospital, Cincinnati, Jan. 17.

**Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106:**

**Gastrointestinal Surgery** — Jan. 16-17.

**Medical Progress for Family Physicians** — Jan. 30-31.

**Family Medicine Review**—Sponsored by the Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214; at the Sheraton Motor Inn North, 888 E. Granville Rd. (State Route 161 at I-71), Columbus; Jan. 5-6 and Jan. 19-20.

**Cleveland Society of Obstetricians and Gynecologists Endocrinology Symposium** — at the Shaker House, 3700 Northfield Rd., Shaker Heights, Jan. 16, 3:00 p.m., with dinner at 7:00 and evening session; guest speaker, Nathan Kase, M.D., Chief, Dept. of OB-Gyn, Yale University.

**Clinical Problems in Allergy** — Akron City Hospital, 525 E. Market St., Akron 44309, Jan. 16.

**Practical Clinical Pulmonary Physiology** — Sponsored by the American College of Chest Physicians, 112 E. Chestnut St., Chicago 60611, and by the Northern Ohio Lung Association, at Case Western Reserve, Cleveland, Jan. 30-Feb. 1.

## February

**Pediatric Workshop** — Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214, at Hueston Woods Lodge, College Corner (Southwestern Ohio), Feb. 8-10.

**Third Annual Symposium on Clinical Pediatrics,** sponsored by Case Western Reserve University, Feb. 12-13. Topic, "Pediatrics, Pragmatism and Pitfalls," includes management problems encountered in medical care of children. Faculty includes Marvin Cornblath, M.D., Frederick Robins, M.D., and Samuel Gross, M.D., Contact, S. S. Strassman, M.D., Chairman, Pediatric Clinical Faculty, Rainbow-Babies' and Children's Hospital, University Circle, Cleveland 44106.

**Common Clinical Problems: Orthopaedic/Neurology** — Akron City Hospital, 525 E. Market St., Feb. 20.

**Ohio State University College of Medicine, Continuing Medical Education Conferences;** for details contact OSU Center for Continuing Medical Education, 410 W. Tenth St., Columbus 43210:

**Infectious Diseases** — Feb. 6.

**Electromyography** — Feb. 11-14.

**Gastroenterology** — Feb. 14-15.

**Nutrition** — Jan. 19-20.

**Orthopaedic Problems** — Feb. 27.

**University of Cincinnati College of Medicine (CONMED):**

**Sixth Annual Infectious Disease Symposium,** at the Shrine Burns Institute, Feb. 21.

**Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106.**

**Blood Banking** — Feb. 6-7.

**Current Concepts in Renal Disease and Hypertension** — Feb. 13-14.

**Diagnostic and Therapeutic Approach to Rheumatic Disease** — Feb. 20-21.

**Sports Medicine** — Feb. 27-28.



# Community Health News

## Ohio Department of Health

JOHN H. ACKERMAN, M.D., Deputy Director

### Prenatal Test for Gonorrhea

Effective December 19, 1973, sections 3701.46 to 3701.50 of the Revised Code are amended to include a prenatal test for gonorrhea. Every pregnant female, as a part of her prenatal workup, must have an examination for gonorrhea. At this time the ONLY accepted test is a properly taken, properly processed culture for gonorrhea. According to the law, such cultures must be made in laboratories approved by the Department of Health as is the case with prenatal serological tests for syphilis. Pertinent information, including the fact that appropriate tests for syphilis and gonorrhea have been made in an approved laboratory

and the approximate date when the specimens were taken, are to be recorded on the birth or stillbirth certificate.

Early discovery and treatment of gonorrheal infections in the female prevents serious complications. However, to prevent infection of the child at birth, the mother must be free from gonorrhea at the time of birth. It is therefore recommended that an examination for gonorrhea be made near the time of delivery.

Questions and requests for further information may be directed to the Ohio Department of Health.

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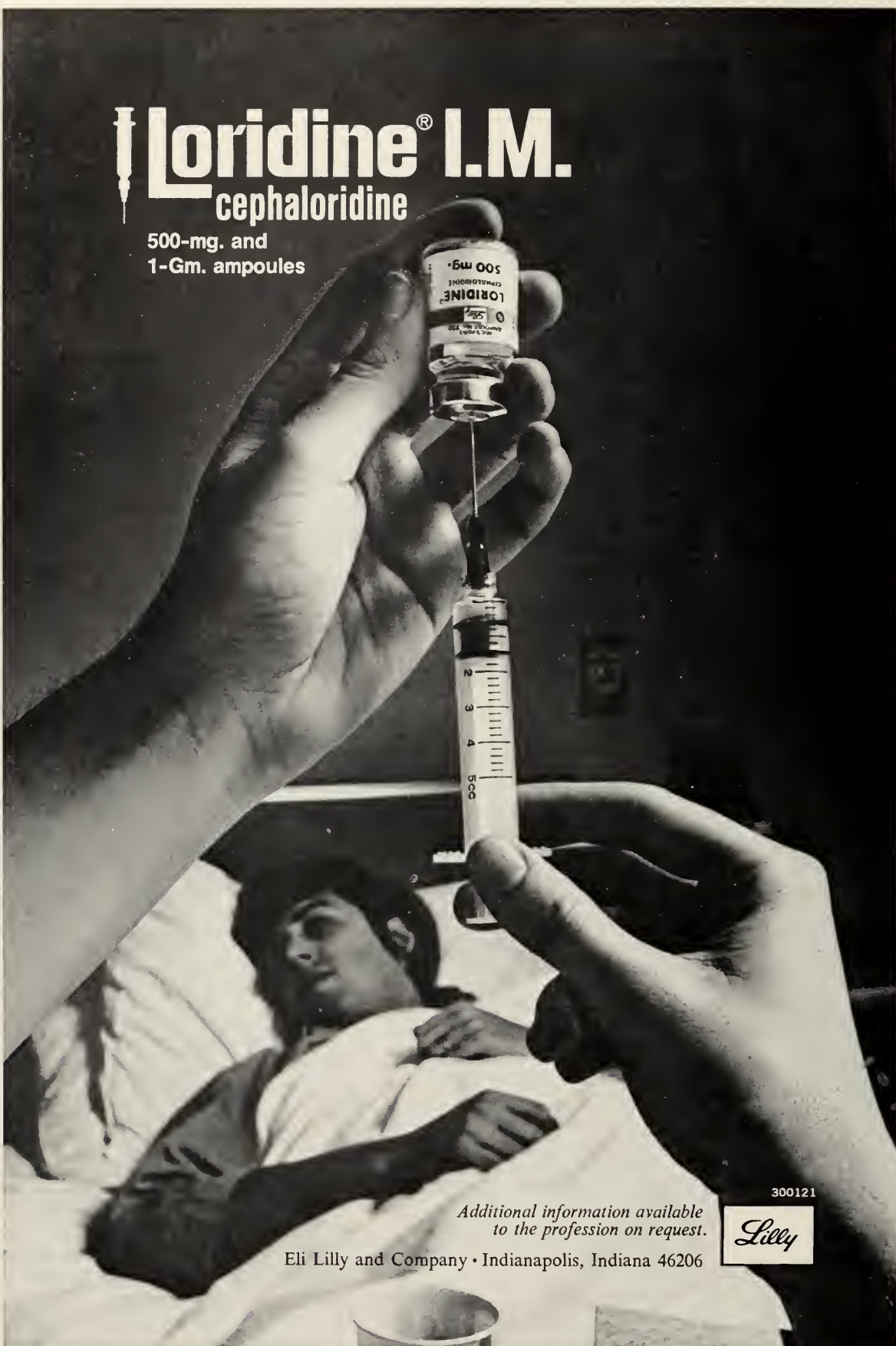
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\*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964



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# Clinical & Scientific Features



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NUMBER 12

## Plastic Surgery in Prison An Apparently Negative Result

JAMES A. LEHMAN, JR., M.D., AND JAMES E. CONKLIN, M.D.

It is acknowledged that neither convict prison, nor the hulks, nor  
any system of hard labour ever cured a criminal.  
(*Fyodor Dostoyevsky—1861*)

REHABILITATION OF CHRONIC offenders is a most difficult problem. Habitual criminals represent the major segment of prison populations and constitute an enormous waste of human resources and public funds. It is estimated that of the 200,000 prison inmates in the United States today at least 40 percent can be expected to return to prison after their release.

The causes of antisocial behavior are multiple and interrelated, but it has been a long-standing feeling that physical defects contribute strongly to this problem. From Quasimodo to the noseless villain of *Cat Ballou*, literature has incriminated physical deformities, especially facial, as a cause of criminal behavior. While this may be an oversimplification of the problem, there can be no doubt that individuals with facial defects develop inferiority complexes which make employment difficult and may contribute to criminal behavior. Correction of these defects definitely enhances the chances of an inmate making a satisfactory adjustment to society after release. Previous studies<sup>1-5</sup>

have shown a reduction of from 9 to 32 percent in the recidivism rate of prisoners undergoing plastic surgery.

In 1956, through the efforts of one of the authors (J.E.C.), the University of Pittsburgh Plastic Surgery Department established a plastic surgery program at the Western Pennsylvania State Correctional Institution in Pittsburgh, utilizing young plastic surgeons in their advanced training. Many states now have plastic surgery programs established in penal institutions and a continuing evaluation of the effectiveness of these programs is necessary. A five-year study was undertaken to assess the contribution of plastic surgery to the rehabilitation of inmates at the Western Pennsylvania State Correctional Institute.

### Material

The five-year period from 1962 to 1967 was selected for evaluation because of the availability of accurate and well-tabulated records. In addition, this allowed for a sufficient follow-up of paroled inmates. During these years, a total of 443 operations were performed on 388 inmates.

Submitted June 1, 1973.



## The Authors

- Dr. Lehman, Akron, is Chief of Plastic Surgery, Akron City and Akron Childrens Hospitals.
- Dr. Conklin, Pittsburgh, is Associate Professor (Plastic Surgery), University of Pittsburgh School of Medicine.

In reviewing these records, it was possible to categorize the presenting problems into five general groups: traumatic facial, congenital facial, hand, tattoos, and miscellaneous problems (Table 1). Over 75 percent of the patients seen had facial deformities (Fig. 1) of which 186 were traumatic and 152 congenital. There were 70 tattoo excisions including both professional and jailhouse tattoos (Fig. 2). Twenty-nine inmates had hand deformities, the majority of which were traumatic. Further analysis of the facial cosmetic surgery is presented in Table 2.

### Results

To evaluate the effectiveness of this program, it was decided to compare the recidivism rate of the operated paroled inmates to the recidivism rate for all parolees of the State of Pennsylvania.

In the group of 388 inmates having plastic surgery, 199 have been released from the institution. Of those released, 127 were paroled and this group was available for evaluation. Of the 127 inmates who were paroled after plastic surgery, 43 (34 percent) were returned to the institution for parole violation. During a similar period, the average recidivism rate for parolees in the State of Pennsylvania was 22 percent.

### Discussion

These figures seem to indicate that plastic surgery does not improve an inmate's chances of

TABLE 1. Distribution of Deformities Among 388 Inmates Having Plastic Surgery

|                   |     |
|-------------------|-----|
| Traumatic facial  | 186 |
| Congenital facial | 152 |
| Tattoos           | 70  |
| Hand              | 29  |
| Miscellaneous     | 6   |
| Total             | 443 |

TABLE 2. Types of Facial Cosmetic Surgery Performed on Inmate Groups

|                |     |
|----------------|-----|
| Rhinoplasty    | 140 |
| Scar revision  | 62  |
| Blepharoplasty | 38  |
| Otoplasty      | 31  |
| Dermabrasion   | 23  |
| Rhytidectomy   | 15  |
| Chin implants  | 5   |
| Total          | 314 |

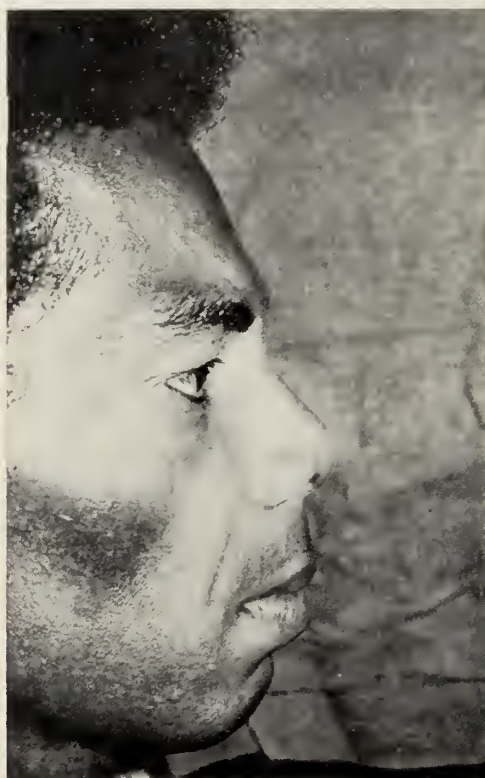


FIG. 1. Saddle nose deformity (left) corrected by cartilage graft (right)



FIG. 2. Typical nonprofessional tattoo (left) removed by dermabrasion (right).

making a satisfactory adjustment to society after parole. Cosmetic surgery, however, is only one of many supportive facets in the rehabilitation program and it is difficult to evaluate the value of this surgery alone. The effect of this surgery can be beneficial, but by itself does not solve psychosocial problems that have existed for years.

Schuring and Dodge<sup>6</sup> showed no decrease in the recidivism rate in 185 inmates having cosmetic surgery. It was their impression that correction of a deformity will not automatically resolve attitudes and habits that have become deeply ingrained. Kurtzberg, et al<sup>7</sup> demonstrated that the prison inmate population has a higher psychopathologic level than average, but that those requesting cosmetic operations had an even higher level than the control group of prisoners. Certainly all these factors influence the inmates' chances of making a satisfactory adjustment after plastic surgery.

The value of this program in postgraduate plastic surgery training is undeniable and from a surgical standpoint, the results were more than satisfactory. In addition, a needed medical service is being provided by the prison authorities which must demonstrate to the inmates an attitude of interest in their welfare.

Further evaluation of our results is necessary if we are to substantiate our impression that plastic surgery for the prison inmate is not only worthwhile, but beneficial from the rehabilitation standpoint. In addition, the use of the recidivism rate as the only measure of success should be replaced by some more reliable system.

### Summary

A study of 127 paroled inmates having plastic surgery revealed no significant alteration in recidivism rate. Such a service is of value in the overall prison rehabilitation program.

Rehabilitation of the chronic offender is a difficult problem and the habitual criminal repre-

sents the major segment of prison populations. It is estimated that 40 percent of the prison inmates in the United States today fall into this category. Previous studies have shown a reduction in the recidivism rate of prisoners undergoing plastic surgery. At the Western Pennsylvania State Correctional Institute in Pittsburgh over a five-year period, 388 inmates had plastic surgery. Of these inmates, 127 were paroled and 43 (34 percent) were returned to the institution. During a similar period, the recidivism rate for all parolees in the State of Pennsylvania was 22 percent. There are many reasons for these results. In spite of the results, a plastic surgery service is of value in the overall prison rehabilitation program.

**Acknowledgment:** Mr. Douglas Keller researched the patients' records, and Mr. Robert Butera of the Pennsylvania State Legislature assisted with the Pennsylvania Parole Board.

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# Failures of L-Dopa

GEORGE W. PAULSON, M.D.

PREVIOUS ARTICLES in this *Journal* have documented the success of L-Dopa and reviewed the side effects of this remarkable new agent. It is apparent that although L-Dopa is the best drug currently available for Parkinson's disease, therapeutic failures are common and may be difficult to explain. This article reviews selected examples of failures in the use of L-Dopa and offers suggestions to lessen the frequency and impact of such therapeutic misadventures.

## Reasons for Failure

### 1. Use of L-Dopa when the indications were equivocal or the diagnosis erroneous.

**Case Summary:** This 60-year-old man had noted a distal tremor of his head and hands for 25 years. The tremor increased with exertion or excitement and was so thoroughly relieved by alcohol that he drank a beer in order to shave. Despite the severe and rapid tremor, he had no rigidity or akinesia. A trial of L-Dopa worsened the tremor, but diazepam and propranolol gave partial relief.

**Discussion:** L-Dopa is of little or no benefit for benign essential tremor. Benign essential, or familial, tremor is faster than parkinsonian tremor, is more likely to be present during action, and is rarely associated with rigidity or akinesia. Many practitioners still confuse benign tremor with parkinsonism. It is true that many experienced neurologists feel there are conditions in which senility, essential tremor, and mild parkinsonism all are merged in the same patient. Therefore, in some cases, clear distinction will be impossible. In such mixed cases, and also in cases with benign tremor, L-Dopa is usually useless.

There are several other movement disorders in which L-Dopa is of no benefit or can even increase the extrapyramidal symptoms. We have seen worsening of two cases of Huntington's chorea after L-Dopa was prescribed. Dystonia musculorum deformans can be helped by small doses of L-Dopa, but larger doses produce an increase in the adventitious movements and tremor which are present in dystonic patients. A few observers have suggested that there is even more need for destructive surgery in patients with dystonia after

## The Author

• Dr. Paulson, Columbus, is Clinical Professor of Medicine (Neurology), The Ohio State University College of Medicine; and Attending Neurologist, Riverside Methodist Hospital.

they receive large doses of L-Dopa. There are other and more esoteric diseases with extrapyramidal features which can be confused with Parkinson's disease.

The most common misuse of L-Dopa in patients with parkinsonism is in a situation where relatively little harm is likely to ensue, namely, a trial of therapy for the senile demented patients found in nursing homes. Many of these patients have both cortical and subcortical disease, and although extrapyramidal features are often present, parkinsonism is not their primary handicap. L-Dopa produces little benefit in this group of patients, though increased alertness or mild activation can result from its use. In some of these institutionalized patients, the complications of L-Dopa, such as gastrointestinal distress, psychic turmoil, or hypotension, complicate medical management and annul any benefits gained from increased motility.

### 2. Inappropriate prescription of the drug.

**Case Summary:** This 63-year-old man had classic parkinsonism, and a significant decrease in his recent memory. When instructed to take L-Dopa with a slow increase of one additional 500-mg capsule per day *per week*, he increased the drug by one additional capsule per day. He achieved a level of 4 gm in eight days, but suffered such severe gastrointestinal distress and confusion that the medicine was discontinued. Not seen for six months, he returned inquiring about new medicines, and for several return visits he refused to try L-Dopa again.

**Discussion:** One of the most common reasons for failure in L-Dopa, particularly when first prescribed, is too rapid an increase in total dosage. If the physician instructs the patient to increase dosage no more than 250 mg per week, so that two months are required to reach 2.5 gm, there

Submitted June 4, 1973.



are very few individuals who cannot tolerate the medicine. When the drug is prescribed more rapidly, or in single large doses, resultant nausea can set up a conditioned response of rejection so intense that the mere thought of the drug leads to vomiting. All patients should be urged to take the drug only during or after meals.

Many patients will be better at regulating the precise time of their dose than their physicians can ever be. Individuals may prefer to take L-Dopa as frequently as every two hours during the waking hours; others do equally well with doses reserved for three times a day. In order to avoid afternoon "freezing" or akinetic episodes, most patients eventually require small doses of L-Dopa between meals or utilize supplementary doses whenever a transient increase in mobility is needed.

It is unwise to withdraw other antiparkinson medication when L-Dopa is initially prescribed. Though far from dramatic in relieving symptoms, these drugs may be a protective margin against aspiration or total inability to maneuver, and the anticholinergics can supplement the effects of L-Dopa.

### 3. Complications of aging as a reason for failure of the medication.

**Case Summary:** This 67-year-old man developed parkinsonism six years earlier, and had primarily akinesia and stumbling problems, though no other major difficulties were apparent. L-Dopa produced modest benefit. The patient had gastrointestinal distress and developed an ulcer while on L-Dopa but, with careful titration, was able to continue the drug. However, he eventually developed incessant abdominal pains, myocardial infarction, a broken hip, and then manifested marked intellectual deficit. This prompted admission to a nursing home, where he continues in a limited environment with disabilities which do not relate primarily to the parkinsonism.

**Discussion:** The phenomena of aging are painfully apparent and can occur in association with parkinsonism, since the average age of the patients is between 65 and 70 years. It is not unusual that the drug appears to fail solely because the patient has become decrepit and aged. It may be difficult, for example in an octogenarian, to be certain whether a slow decrease in mental function relates to the use of L-Dopa, to the progressive brain atrophy that can occur with parkinsonism, or if dementia is a normal concomitant of longevity. L-Dopa can even temporarily mask the development of another disorder, as in one patient with stomach cancer whose gastrointestinal distress was erroneously attributed to L-Dopa.

### 4. Progression of parkinsonism.

**Case Summary:** This 58-year-old man had slowly progressive parkinsonism, primarily manifested as akinesia. He was admitted to the hospital where remarkable improvement occurred

with L-Dopa, so dramatic that he was used in a film for teaching purposes. Over the next six months, he remained well but then gradually deteriorated. Despite his youthfulness and great motivation, he was back in a wheelchair within two years, after a promising but elusive brief period of normality. He was finally limited to a nursing home because of akinesia, rigidity, and difficulty with swallowing. Cachexia, aspiration, and death followed.

**Discussion:** Unfortunately, despite some initial opinions to the contrary, parkinsonism progresses no matter how good a drug L-Dopa may be. We have seen dozens of patients in whom senility is not the major cause of deterioration, in whom scarring following prior surgery is not an explanation of their progressive disease, and in whom it also appears clear that the basic parkinsonism has continued to worsen. The patients often improve for one to two years, perhaps are stable for two to four years while on L-Dopa, but then they slip away from control and a rapid deterioration begins despite manipulation of the dosage or timing of the drug, utilization of other medications, and psychological or physical therapy.

In an effort to postpone or ameliorate this decline, amantadine hydrochloride has been used in over 75 patients at a dose of 100 mg twice a day. In about 30 percent of parkinsonian patients it is a beneficial adjunct to L-Dopa, but, unfortunately, it tends to lose its effectiveness in a few months. Some of the other standard antiparkinson medications, such as benztropine mesylate or trihexyphenidyl HCl, are also beneficial for selected patients on L-Dopa. However, since at least 10 percent of patients have intellectual disturbances or nocturnal confusion when on these anticholinergic drugs, they are a mixed blessing.

It has been hoped that some of the new decarboxylase inhibitors will be of benefit to delay progression of the disease, but most appear to act primarily to lessen the side effects of L-Dopa and to reduce the dose required for optimal effect. Despite this or any other approach, there is no reason to suppose that drugs, even L-Dopa, can ever completely prevent the progression of parkinsonism.

### 5. Depression.

**Case Summary:** This 68-year-old minister-to-the-deaf developed parkinsonism about five years before he was first seen, and this interfered with his rapid hand movements and ability to communicate. He responded dramatically to L-Dopa, with almost total amelioration of both his tremor and his rigidity. Approximately four months after starting on the drug, however, he suddenly returned from over a 1,000 miles away for an emergency visit saying that the disease had rapidly progressed. In talking to him, however, there was no major change except for extreme depression.

Physically, he did not shift in his pattern during this time from the point of view of his parkinsonism, and the depression responded well to amitriptyline HCl. It has recurred twice in the three years since, each time responding well to antidepressants.

**Discussion:** For reasons that are not clear, about six months after starting on L-Dopa many patients develop depression. Such a "let down" feeling is probably due to several factors. For many, there is disappointment that the disease was not totally erased by L-Dopa, or that life isn't as full as it once was. Since this disappointment is so common, it is important to orient the patient when the drug is started. There also may be biochemical changes related to L-Dopa and these can produce depression in some patients. Because of its atropine-like qualities and its value as an antidepressant amitriptyline HCl is a useful supplementary agent for depression in parkinsonism.

#### 6. Inadvertent use of pyridoxine.

**Case Summary:** This distinguished man, age 65 years, had severe parkinsonism, manifested primarily by postural difficulties. His improvement with L-Dopa was only approximately 50 percent, but he was able to resume some activities and self-care. Striking abnormal involuntary movements occurred, and he was placed on therapy with pyridoxine, 100 mg twice a day, in an effort to ameliorate these. Approximately two hours later, his parkinsonism was worse than it had ever been before.

**Discussion:** For most patients, a small amount of pyridoxine doesn't diminish the effectiveness of L-Dopa, or if pyridoxine is used, additional amounts of L-Dopa can offset the pyridoxine effect. Pyridoxine does increase metabolism of L-Dopa and lowers its effectiveness. At least five patients have been seen who received a dose of pyridoxine inadvertently in cereal, or as a multivitamin medication. Special diets without pyridoxine are available from all the drug companies which market L-Dopa, but as mentioned, rigid dietary control is usually not required.

#### 7. Dyskinetic side effects of L-Dopa.

**Case Summary:** This 67-year-old woman had severe parkinsonism for many years with partial relief from L-Dopa. Her major problem, however, consisted of dyskinesia which limited the use of the drug to about no more than 3 to 4 gm. The dyskinesia involved her neck and shoulder, and she also developed an incessant urge to talk. The dyskinesia and the logorrhea were intermixed with occasional freezing or "on-off" episodes.

**Discussion:** In addition to the obvious fact that the most limiting side effect of L-Dopa is dyskinesia, many patients do have an "on-off" phenomenon later in the course of the disease. With this, there is a sudden shift from excessive or normal activity to freezing, which can be quite

disconcerting to the patient. The "on-off" effect can be partially relieved by a low protein diet and by regulation of dosage of the drug.

It is harder to treat dyskinesias which involve primarily the mouth, arms, shoulders and some writhing movements of the fingers. Dyskinesia is only partially benefited by reduction in the dosage or by rearrangement in the time of administration. Dyskinesias can occur in any patient who has parkinsonism, even after taking L-Dopa for some months. The appearance of dyskinesias usually establishes the upper limit for L-Dopa. In order to avoid these, we now use lower doses than were once recommended.

#### Summary

As can be seen from this discussion, there are several aspects of the use of L-Dopa that should be noted.

1. The medication should be used only for parkinsonism, and disappointment can be expected if the patient does not have this disorder.

2. Parkinsonism tends to progress despite the use of L-Dopa, therefore, deterioration will be noted in patients. Many features will not be ameliorated by the drug. It seems likely that, in particular, mental changes progress despite adequate use of L-Dopa.

3. Many patients develop depression which may be due both to the use of L-Dopa and to disappointment because the parkinsonism is not totally cured.

4. Other aspects of aging occur in these patients. Specifically, heart disease, chronic pulmonary disease, and carcinoma will frequently occur.

5. Dyskinesias will interfere with complete success in many patients who receive a dosage range above 3 gm. For this reason, it is now becoming accepted therapy to keep the total range below 3 gm in most patients. In many patients, the dosage might even be reduced after the medication has been used for several years.

L-Dopa remains, by a substantial margin, the best single drug for parkinsonism. The fact that some patients fail to respond does not mean that the drug should be avoided, and indeed, it is the initial drug of choice. When it is administered properly, increased slowly, and presented as a benefit but not a cure-all, most patients will note significant benefit for several years before the parkinsonism overtakes them again. The fact that the physician is haunted by a sad personal awareness of the eventual decline of the patient is no reason to present the drug in a defeatist manner. The awareness of the possibility of failure is the purpose of this article. Because of such eventual failure, the physician must temper his enthusiasm with both realistic appraisal and a willingness to try additional measures; and should be willing to re-emphasize the necessity for continued physical effort and courage on the part of the patient.

# Vitamin E: Who Needs It?

## III. Or Who Doesn't?

DAVID K. MELHORN, M.D.

IN A RECENT EDITION of *Nutrition Today*,<sup>1</sup> an excellent review of the biochemical and therapeutic status of vitamin E by Tappel was highlighted by the cover of that journal which visually captured the crux of the present knowledge about vitamin E. The cover picture by the artist, Don Crowley, depicts a scientist wielding a butterfly net, but unable to catch the elusive vitamin E butterfly.

The first two sections of this review<sup>2,3</sup> discussed present knowledge concerning the causes of vitamin E deficiency in the human and its relationships to the disease states in which it occurs. In this final portion of the discussion, we will attempt to consider the widespread use of vitamin E as a therapeutic agent in a variety of conditions not associated with demonstrable vitamin E deficiency. This attempt, as will be seen herein, may be quite difficult.

In his opening remarks to a symposium conducted by the New York Academy of Sciences, Dr. H.J. Kayden<sup>4</sup> described the scope of the Academy's program in this way: "It was our intent . . . that we should limit our program to the *strictly* scientific, factually verified material on vitamin E, and should avoid areas in which the role of to-

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copherol has not been adequately established, even though clinical reports may be suggestive. . . I have received several communications from serious students of vitamin E who have suggested that reports on the role of tocopherol in ischemic vascular disease, in occlusive peripheral vascular disease, in aging, and so on, be included in this program. We have chosen not to do so."

### What Is "Strictly Scientific?"

What Is "Strictly Scientific"? Statements such as that of Dr. Kayden have occasioned frequent, often strident retorts from a myriad of sources during the past 40 years. They contain a number of common themes which are summarized below:

1. ARGUMENT: Vitamin E has a biologic role in the human other than that of a cellular antioxidant.

(A) COROLLARY—Administration of vitamin E may benefit patients who are not, by accepted means of evaluation, vitamin E deficient.

COMMENT: There are, in fact, a number of reasonable and intriguing laboratory and clinical studies which indeed indicate that vitamin E has a role in human biologic functions not directly related to its properties as an antioxidant. For ex-

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Reprint requests to Rainbow Babies and Childrens Hospitals, 2103 Adelbert Road, Cleveland, Ohio 44106 (Dr. Melhorn).

Submitted September 17, 1973.



ample, a current suggestion based on firm evidence,<sup>5,6</sup> is that vitamin E plays a regulatory role in the synthesis of heme and production of certain cellular proteins. In patients with porphyria cutanea tarda studied by Murty, et al, the administration of vitamin E decreased the urinary excretion of porphyrins, which are characteristically abnormally elevated in this disease. The response was apparently mediated by a regulatory action of the vitamin on aminolevulinic acid synthetase, an enzyme important in the production of the heme moiety. Clinical symptoms also improved.

Thus, we can cautiously accept the premise of the first argument and corollary, *if* appropriate and accurate documentation of such situations is forthcoming.

2. ARGUMENT: Vitamin E deficiency in lower animals produces a variety of disease states, eg, sterility, dystrophic muscular degeneration, and others.

(a) COROLLARY—Large amounts of vitamin E can correct “similar” conditions in the human, even though vitamin E deficiency may not be demonstrated in such states.

COMMENT: Here, the argument is correct, but the corollary is basically fallacious. Implicit in the corollary are two erroneous equations which have resulted in the most frustrating and nonproductive facets of clinical research on the effects of vitamin E on diseases of humans. The first equation:

Apples = Pears

That is, disease states in lower animals caused by vitamin E deficiency can be equated with “similar” conditions in vitamin E-deficient humans. It is quite true that vitamin E deficiency affects many experimental animals in a wide variety of adverse ways involving a number of organ systems. Our previous discussion regarding the premature infant might appear to support the corollary. However, the cellular make-up of the premature infant early in its life is unique. As mentioned briefly in Part I of this review,<sup>2</sup> the human red blood cell and cells of other tissues in the older infant and adult have multiple mechanisms for detoxification of peroxides which are nonexistent or deficient in the lower animal. The human erythrocyte and other tissues are, for example, rich in the enzyme catalase, which converts hydrogen peroxide to oxygen and water. This enzyme is often found in very low levels in experimental animals. It is therefore not surprising that a host of pathologic conditions seen in lower animals have no counterpart in the vitamin E-deficient human.

The second fallacious equation can be stated:

Apples = Goats

In other words, the corollary also implies that pathologic changes seen in vitamin E-deficient animals can be related to morphologically or clinically similar features seen in human disease states.

When such apparent similarities are observed, possible relationships obviously must be investigated. When careful and well-controlled studies show clearly that vitamin E has no etiologic or therapeutic role in a given condition, the physician prescribing vitamin E is simply offering a relatively expensive placebo.

Two examples (of many) can be cited. First, there were bright hopes in the 1950's that the dystrophic muscle changes seen in the vitamin E-deficient rat were comparable to those found in muscular dystrophy in man. Unfortunately, children with muscular dystrophy are neither vitamin E deficient, nor react favorably to massive doses of the vitamin.<sup>7</sup> Yet, vitamin E is still given to many children, for reasons known only to their physicians.

We also touch briefly (very briefly) on the emotionally-charged controversy about the relationship between vitamin E and sterility. Very simply, while vitamin E deficiency may produce sterility in rats and some other species of lower animals, vitamin E deficiency has *never been shown* to be a cause of sterility in humans. Further, there is absolutely no reasonable evidence that vitamin E administered to the human increases sexual desire or sexual potency. The testimonials to the contrary by “satisfied users” are a credit to them, not to the effects of tocopherol.

3. ARGUMENT: Many patients with a variety of clearly and not-so-clearly defined illnesses claim improvement following the “therapeutic” administration of vitamin E.

(A) COROLLARY—The patient's subjective response is a much better way to evaluate the effects of vitamin E than in vivo or in vitro laboratory studies.

COMMENT: This argument and corollary and the obvious implications contained in them can be easily analyzed by any responsible practicing physician. Certainly, the patient's subjective description of his response to any therapeutic regimen is important, but cannot be accepted as the sole measure of a drug's efficacy. A list of condi-

Some of the “Uses” for Vitamin E\*

|   |                     |
|---|---------------------|
| T | hrombosis           |
| O | vulatory regulation |
| C | ancer               |
| O | ld age              |
| P | aptic ulcer         |
| H | emorrhoids          |
| E | rythema bullosum    |
| R | heumatic fever      |
| O | dor control         |
| L | upus erythematosus  |
| S | cleroderma          |
| A | cne                 |
| I | nfertility          |
| D | iabetes mellitus    |

\*The voluminous list of conditions for which vitamin E has been recommended makes this anagram easy to prepare.

tions for which vitamin E therapy has been advocated is shown in the table. This list is quite incomplete, but it sketches the incredible diversity of such conditions. In each instance no *firm* scientific basis for vitamin E therapy has been found.

4. ARGUMENT: Not enough research has been done on the effects of vitamin E therapy in a number of diseases not associated with vitamin E deficiency.

(A) COROLLARY: Therefore, it is unfair to criticize the use of vitamin E in any such condition until further investigation is carried out.

COMMENT: This argument and its corollary pose subtle problems for the responder. As in all other areas of scientific investigation, *enough* research has *not* been done on the effects of the tocopherols in human biologic systems. However, the corollary, to be acceptable should read, "It is unfair to criticize the use of vitamin E in any such situation *as part of* a critical evaluation of its effects." Unless careful investigations, usually requiring double-blind technics, are employed, the medical and scientific communities will be guilty of creating for vitamin E its own special "limbo." Witness, for example, the brouhaha surrounding the use of vitamin E for the prevention or control of coronary artery disease. Many cardiologists in other parts of the world include vitamin E as a *routine* part of their therapeutic regimen for patients with coronary disease, despite the fact that carefully controlled studies in such patients<sup>8</sup> showed no beneficial effects.

5. ARGUMENT: No major side effects of the prolonged administration of large amounts of vitamin E have been reported.

(A) COROLLARY—In any given disease, vitamin E may have no beneficial effect, but there is no harm in trying it.

COMMENT: The argument is an interesting one. It is known that many individuals have taken large amounts of various tocopherols for long periods of time without *apparent* ill effects. However, we note with equal interest the recent proposals of the Federal Food and Drug Administration regarding control of the amount of vitamins, including vitamin E, which can be sold or prescribed. It may be that side effects have not been documented because our admitted limited knowledge of the actions of the tocopherols in human biologic systems also limits our ability to identify toxic effects.

There are at least two reports of abnormalities associated with large doses of vitamin E. Elevated urinary excretion of creatinine has been noted,<sup>9</sup> and interference with response to iron therapy in iron-deficiency anemia has also been observed.<sup>10</sup> It is almost a paradox that many of those who make sweeping claims for the efficacy of vitamin E are also those who *claim* that large doses of the vitamin have no toxic side effects. Recent medical

history certainly provides enough examples concerning the use of "therapeutic agents" to make caution entirely and necessarily appropriate.

6. ARGUMENT: Many people do not have diets which provide an adequate intake of tocopherols.

(A) COROLLARY—Supplementary vitamin E should be routinely recommended.

COMMENT: Assuming a diet not wildly unusual, normal intestinal absorption, and normal utilization, it is almost impossible for adult individuals in this country to become vitamin E deficient. Advocates of additional supplementation frequently point to the difficulties in establishing a minimum daily requirement for the vitamin. However, extensive analyses of serum and tissue levels of tocopherols, in addition to indirect in vitro laboratory measurements of vitamin E status, such as the erythrocyte H<sub>2</sub>O<sub>2</sub> hemolysis test, have established reasonable guidelines as to the intake of tocopherols necessary to maintain vitamin E sufficiency. Average diets easily supply tocopherols in the recommended range of 5 to 30 international units.

7. ARGUMENT: The "organized" medical and scientific profession are suppressing information about the benefits of vitamin E therapy in an effort to avoid competition with "nutritional advisors," advocates of vegetarianism, and proponents of "natural diets" and "health foods."

(A) COROLLARY—Ignore the studies and advice of the "organized conspirators."

COMMENT: So, vitamin E has joined the company of copper bracelets, krebiozen, healing waters, and radium caves. The argument and corollary carry triple dangers. Dr. Tappel succinctly phrases the first. "... the notoriety of vitamin E on the lunatic fringe of society has, no doubt, caused many competent investigators to abjure vitamin E research."<sup>1</sup> The same is also probably true for organizations who might fund such research. Second, irresponsible and unsupported claims for the efficacy of this agent in conditions ranging from pimples to piles enrich corporate coffers at the expense of the medically unrewarded patient. It took only three weeks for our laboratory technicians to compile the "commercial" collage seen in the figure. Third, the practicing physician is embroiled in the middle of the controversy. Questions are asked of him such as: "Are vitamin E deodorants safe and effective, Doctor?" "Can I live longer if I take vitamin E, Doctor?" "Does vitamin E cream give me a better suntan, Doctor?"

### Summary: A Smidgen of Perspective

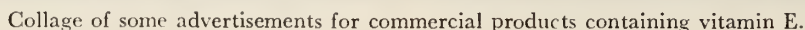
In these three articles, we have considered the status of our knowledge of the function of tocopherols in the human. In our exploration of



We have also considered in Part II, disease states where vitamin E deficiency is common but not clearly associated with the basic pathologic processes or clinical findings. In most of these conditions, such as cystic fibrosis, defects in intestinal absorption of fats are the primary cause of vitamin E deficiency. However, in at least one situation, Type II congenital dyserythropoietic anemia, vitamin E lack appears to be the result of heightened requirement for the vitamin. Further investigation is obviously important in such disease states, both malabsorptive disorders and hemolytic anemias. In this regard, it was seen that

Finally, we have explored briefly the use of tocopherols in conditions where vitamin E metabolism is, at best, uncertain. In at least one type of porphyria, vitamin E appears to regulate some steps in the synthesis of heme; vitamin E therapy seemed clinically beneficial. However, the myriad of conditions in which vitamin E has been used therapeutically despite the failure to show the existence of vitamin E deficiency or objective measurement of the improvement upon administration were not considered in detail. For many years, the patient efforts of serious investigators have helped elucidate the functions of the tocopherols. They, and vitamin E, deserve a better fate than being associated with underarm deodorants.

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## E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.\*

This 38-year-old woman comes in with a two-month history of progressive redness and scaling on both ears and later drainage. (See figure.)

What steps should be taken in making the diagnosis and what treatment is indicated?

(See p. 911 of this issue for further information and discussion.)



Patient had progressive redness and scaling of both ears.

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Submitted July 12, 1973.

# Metaplasia in the Urinary Tract

MADHAV K. ADIGA, M.D.

THE CONDUCTIVE urinary tract, extending from the calyces to the urethral meatus, is mostly lined by the transitional epithelium. The exceptions are:

1. In the male urethra — the proximal urethra is lined by transitional epithelium, but the mid-urethra is lined by stratified columnar epithelium up to the fossa navicularis, and the distal portion of the fossa navicularis is lined by squamous epithelium.

2. In the female — the proximal urethra is lined by transitional epithelium and the distal part by the stratified squamous variety.

## Etiology of the Metaplastic Changes

Normal mucosa, when physiologically worn out, is replaced by an identical lining, but when it is subjected to various stresses, there is a change in the lining which may, in fact, be a protective phenomenon. True metaplasia in any mucosal surface is due to altered function and environment.

Metaplasia in the transitional epithelium (urothelium) is due to chronic irritation. Factors which bring this about are chronic infection, calculus formation, attrition, drying, vitamin A deficiency, chemical irritation, and other stresses.

Transitional epithelium is very susceptible to metaplastic changes in the direction of squamous cell or columnar cell type. These changes may occur in patches or extensively. For example, the entire mucosa may be replaced by squamous epithelium. Metaplastic mucosa is prone to malignant changes, hence the newly formed squamous epithelium may be the seat of squamous carcinoma. Squamous carcinoma may also arise from metaplastic changes in transitional carcinoma or from leukoplakia patches, as indicated in the following schema:

|             |                          |                             |
|-------------|--------------------------|-----------------------------|
|             | Adenocarcinoma           |                             |
|             | Columnar epithelium      |                             |
|             | <u>Transitional Cell</u> |                             |
| Leukoplakia | Squamous epithelium      | Transitional cell carcinoma |
|             | Squamous cell carcinoma  |                             |

Different terminologies have been devised for these changes. According to Anderson,<sup>1</sup> when the worn out transitional epithelium is replaced by the

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same type, it is called normoplasia; when replaced by the squamous type, it is prosoplasia. He considers the change toward glandular type as true metaplasia.

Melicow<sup>2</sup> calls these reversions in the urothelium to the cellular characteristics of the formative embryonal stages as retroplasia.

## Illustrative Cases

**Case 1.** — Here, the transitional epithelium had shown squamous metaplastic changes. There was no evidence of any malignant change.

This was a 36-year-old woman, who gave a long history of lower urinary tract complaints and was found to have a urethral diverticulum containing a calculus. The calculus was removed and the diverticulum was excised surgically. Histologic examination of the wall of the diverticulum showed squamous metaplastic changes (Fig. 1). Factors which caused metaplasia were:

|   |       |
|---|-------|
| Stasis of the urine in the diverticulum |       |
| Infection                               | Stone |
| Metaplasia                              |       |

**Case 2.** — In this case, the process of metaplasia had progressed further to the stage of carcinoma.

This was a 78-year-old white woman admitted for a palpable, painful left kidney. On intravenous pyelogram, this was found to be a nonsecreting kidney. Retrograde pyelogram showed a filling defect in the renal pelvis (Fig. 2). This kidney was explored transabdominally. There was a tumor arising from the renal pelvis spreading on the same kidney and the regional lymph nodes. The entire tumor mass was successfully resected. Postoperatively, the patient was apparently well for two weeks, but later she went progressively downhill and died. Histopathology of the tumor was reported squamous carcinoma of the renal pelvis (Fig. 3).

**Case 3.** — A 68-year-old white woman, with no history of urologic complaints, was admitted with left flank pain of two weeks duration. The only positive finding was urinalysis, which showed microscopically 15 to 16 white blood cells (WBC) and 10 to 12 red blood cells (RBC) per high-power field and many epithelial cells. Intravenous pyelogram showed bilateral smooth,

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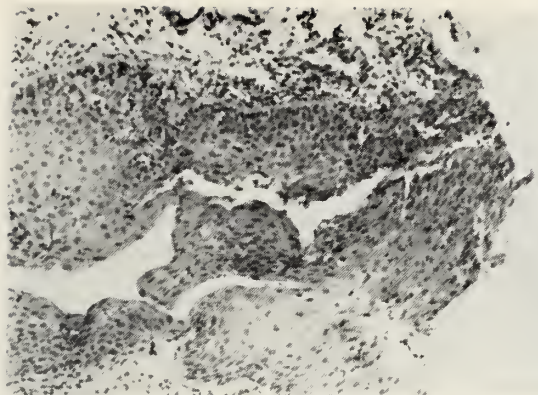


FIG. 1. Photomicrograph of urethral mucosa showing squamous metaplasia (case 1).

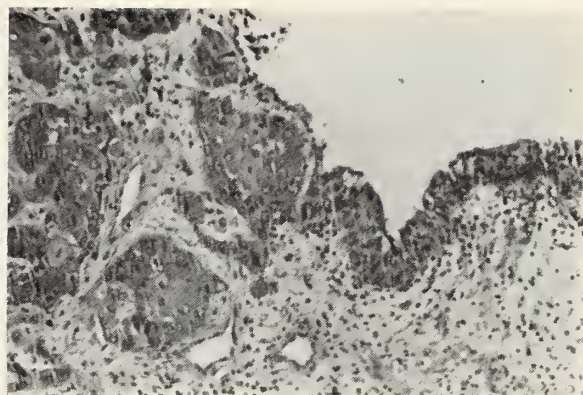


FIG. 3. Photomicrograph showing squamous carcinoma of renal pelvis (case 2).



FIG. 2. Retrograde pyelogram showing extensive filling defect in left renal pelvis and calyces (case 2).

rounded, filling defects in the renal pelves and ureters. Cystoscopy revealed small, multiple cystic areas, especially in the base of the bladder. The patient was started on long-term antibiotic therapy. Comment: This patient evidently has pyelo-uretero-cystitis cystica. The metaplasia here is extensive. In the long term, these areas may be the seat of adenocarcinoma.<sup>3-5</sup>

### Summary

Metaplasia in the urinary tract is an infrequent occurrence. It can occur when the epithelium is subjected to chronic irritation, and this may be either of squamous or columnar type. Further, these may proceed to their respective type of malignant tumor.

**Acknowledgment:** The author is grateful to Drs. W. H. van Fossen, G. Graciansky, Urologists; Dr. R. C. Metzger, Pathologist; and Miss L. Lombardi, Photographer, Barberton Citizens Hospital, who assisted in the preparation of this paper.

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# Massive Leiomyoblastoma of the Stomach

## A Case Report

MYSORE S. N. MURTHY, M.D., and JACK E. TETIRICK, M.D.

"LEIOMYOBLASTOMA" has become an entity accepted by both pathologists and clinicians since the lesion was first delineated by Stout in 1962.<sup>1</sup> The majority of these neoplasms originate in the stomach, the remaining occurring in small intestines, retroperitoneum, uterus, omentum, and other soft tissues. Twenty-six out of a series of 44 cases of gastric and extragastric leiomyoblastomas reported recently by Lavin, et al<sup>2</sup> arose in the stomach. The gastric leiomyoblastomas vary from small lesions measuring 1 cm or less to massive lesions, which frequently extend to extragastric locations. The purpose of the present paper is to report a case of massive gastric leiomyoblastoma, which was successfully resected.

### Case Report

A 59-year-old man was admitted to Riverside Methodist Hospital with the chief complaint of weight loss and increasing abdominal girth. He had noted a gradual and poorly documented weight loss of approximately 18.2 kg (40 lb) until one month prior to admission when he started to lose weight at a rate of 1.8 kg (4 lb) a week. He had maintained an excellent oral intake and was puzzled because of the unremitting weight loss. He also complained of fatigue, occasional anorexia, and fullness but had not had nausea or vomiting. He had noted an increasing size of his waist measurement and complained of occasional night sweats. The patient became aware, in the two weeks prior to admission, that the abdomen was very distended and quite firm. He had some pain above the right costal margin. He had no hematemesis. The system review was negative.

Past medical history was significant in that he had had dizzy spells for 15 years and deafness in the right ear which progressed to attacks of nausea and vomiting

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for which he had been admitted on the neurosurgery service in 1964.

The physical examination showed a man with evidence of weight loss of the extremities. A huge protuberance of the abdomen was thought by some observers to be ascites and by others to be a solid tumor. By rectal examination, a large, firm pelvic mass could be palpated.

Laboratory data included a normal electrolyte profile, fasting blood glucose of 100 mg per 100 ml, and normal liver function studies. Hemoglobin level was 12.6 gm per 100 ml, and leukocyte count was 9,700 per cu mm, with 76 percent neutrophils and 12 percent lymphocytes.

X-ray films included a normal chest film, a normal gallbladder examination, a normal intravenous pyelograph, except for displacement of both ureters bilaterally by the pelvic portion of a large, ill-defined, pelvic mass. The bladder dome was also flattened by this pelvic mass. There was increased density in the left upper quadrant and flank area indicating presence of a very large, ill-defined spleen or extensive mass in the left side of the abdominal cavity. Barium enema was intrinsically normal except that the colon was elongated and redundant, and the upper portion of the redundant sigmoid and splenic flexure was displaced medially and posteriorly by the large abdominal mass. Upper gastrointestinal series showed a normal esophagus with the stomach displaced

Submitted January 24, 1973.

upward by the intra-abdominal mass. There was a 4-cm, cone-shaped projection from the posterior inferior aspect of the gastric wall, which was interpreted either as a deep ulcer or a traction deformity on the gastric wall. The duodenum was normal. The jejunum was displaced to the right and posteriorly. Findings from liver and brain scans were normal.

The patient was seen in consultation and scheduled for laparotomy with a preoperative diagnosis of adenocarcinoma of the stomach. The suggestion was made by the consultant that this might be a benign tumor of the gastric wall such as a large leiomyoma or leiomyosarcoma because of the presence of the deep pit shown on the x-ray film and the absence of interference with gastrointestinal function.

At laparotomy, there was a convoluted, flesh-colored tumor extending from the xiphoid process to the symphysis pubis, filling the entire pelvis and extending superiorly to the liver, and spleen on the left side. All of the mobile, intra-abdominal viscera were crowded into the right upper quadrant. Although this mass had the texture and feel of a solid tumor, it did not invade the parietal peritoneum, nor were any separate nodular metastatic metastases noted in either the solid parenchymal organs or in the hollow viscera. The mass entirely occupied the omentum, but on careful palpation, it was not adherent to any other intra-abdominal structure except the posterior wall of the stomach. Frozen-section diagnosis of leiomyoblastoma was made on a biopsy excised from this tumor. The operation was therefore continued. The mass was gradually mobilized and totally removed along with the omentum and a 4-cm margin of the posterior gastric wall.

**Description of the lesion: Gross**—The specimen consisted of two massive, lobulated, neoplastic masses of approximately equal size, each measuring 30 X 25 X 8 cm in greatest dimensions (Fig. 1), and together weighing 7,250 gms. The omentum formed a thin capsule over the masses which were composed of lobules of fleshy, reddish-grey, smooth, homogenous tissue. A few small and inconstant foci of hemorrhage and fibrosis were present.

**Microscopic examination** of multiple sections from different areas of neoplastic masses revealed a highly vascular neoplasm composed of fascicles of oval to spindle-shaped cells which appeared round in cross sections (Fig. 2). The nuclei were moderately pleomorphic, oval, round, or elongated; the cytoplasm was frequently vacuolated with some of the cells containing a large vacuole in the cytoplasm pushing the nucleus to one side. These vacuoles did not stain positive in fat stains, PAS stain, or mucicarmine stain, and were not seen in the frozen section. The stroma of the neoplasm was formed by a smooth homogeneous, hyaline substance which was rich in acid mucopolysaccharides as demonstrated by alcian blue stain. No mitotic activity was noted despite the massiveness and cellularity of the neoplasm. The mesothelial covering of the neoplasm was not infiltrated.

The patient's postoperative convalescence was uncomplicated and he was afebrile. He was discharged on the ninth postoperative day and has continued to have a normal convalescence with a weight gain of 13.6 kg (30 lb) in the first three postoperative months. He has normal gastrointestinal function.

## Discussion

Leiomyoblastomas (synonym: bizarre leiomyoma; epithelioid leiomyoma) of the stomach vary from small incidental lesions to massive tumors that fill the entire abdominal cavity. The largest gastric mass on record<sup>3</sup> was described as measuring 30 X 20 X 8 cm and was reported to be contained within the leaves of the omentum. In our case, two masses each measuring 30 X 25 X 8 cm and together weighing 7,250 gms, were removed, clearly making it the largest leiomyoblastoma ever re-

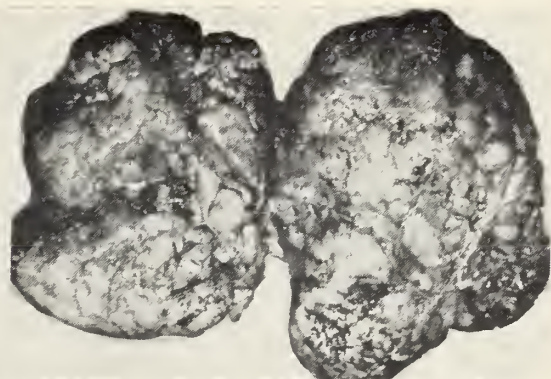


FIG. 1. Gross appearance of neoplastic masses. Note thin strands of fibrous tissue of omentum coursing over fleshy lobulated neoplasm.

corded to the best of our knowledge. It should be mentioned that the neoplasm was a single bilobed mass and had to be removed as two separate masses.

Histologically, the clear or vacuolated cells are quite characteristic. This vacuolated or clear cytoplasm seems to be an artifact as it is not present in frozen sections of the fresh tissue that is stained by hematoxylin and eosin. No mucin or fat is demonstrable within this cytoplasm.

The malignant potential of this neoplasm is variable. Lavin, et al,<sup>2</sup> on the basis of follow-up of 44 cases, emphasizes that tumors larger than 10 cm in diameter, coupled with nuclear hyperchromasia, more than one mitotic figure per high-power field, and clinical symptoms longer than six months are usually associated with bad prognosis, although they hasten to add that the clinical behavior cannot be predicted on histopathology alone. Based on their experience of a 38 percent mortality rate within an average of three years in cases of gastric leiomyoblastoma, they recommend

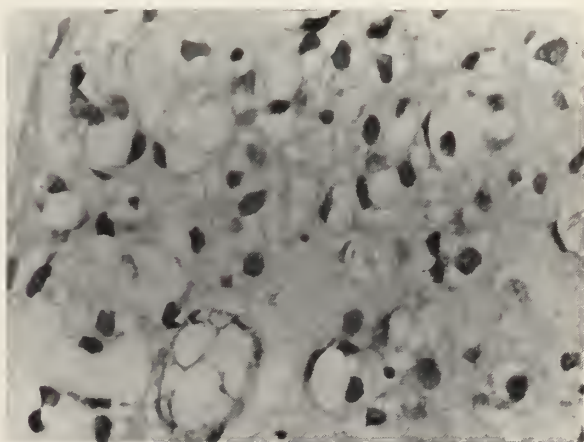


FIG. 2. Histologic appearance of neoplasm. Note vacuolated appearance of cells and homogeneous stroma.

that the leiomyoblastomas should be considered potentially malignant and likely to behave as leiomyosarcoma. In our case, there was no increased mitotic activity in the neoplasm which had not infiltrated any of the abdominal organs, nor were there any metastases in abdominal lymph nodes or liver. Although careful follow-up is mandatory in our case, to date, the patient is alive and well without any sign of recurrent or metastatic disease four months after surgery.

### Summary

This patient is presented as having a rare and interesting massive benign tumor of the gastroin-

testinal tract. Its greatest significance, however, is to reinforce the sound medical principle that patients should not be assumed to have incurable carcinomatosis without an adequate procedure which attempts to define operability and to proceed with resection if at all possible.

### References

1. Stout AP: Bizarre smooth muscle tumors of the stomach. *Cancer* 15:400-409, 1962.
2. Lavin P, Hajdu SI, Foote FW Jr: Gastric and extragastric leiomyoblastomas: clinicopathologic study of 44 cases. *Cancer* 29:305-311, 1972.
3. Wolf JS: Massive leiomyoblastoma of the stomach. *Arch Surg* 96:284-288, 1968.

## Rx: Supplemental Diet for The Ohio State Medical Journal

**YOU'VE NOTICED**, Doctor, that your *Journal* has been a bit thin lately. We didn't plan it that way. *The Journal's* principal financial diet is ethical advertising. More than half of *The Journal's* production cost is paid from advertising revenue (and in previous years, advertising has paid for as much as three-fourths of the cost of publication). Advertising plays a two-fold part in a professional publication. It helps pay the bills, but it also is a great source of continuing medical education.

Please turn to page 936 for a list of companies advertising in this issue of *The Journal*. (Other advertisers may be represented in other issues.) You may wish to keep this list handy and refer to it when detail men call on you. Thank those detail men whose companies are supporting your *Journal* with their advertising and remind the others that they should be doing so. After all, this is THE official publication of the Ohio State Medical Association, not just another GENERIC PUBLICATION. —*The Publication Committee*



# Maternal Deaths Involving Obesity\*

BY THE OSMa COMMITTEE ON MATERNAL HEALTH

PROBLEMS concerning the *obese* obstetric patient have come before the Committee consistently during the past 18 years. Therefore, we devote this column to this timely subject. Examining 1508 cases in our files, we found 225 patients were *obese*;† 210 of these were among 1128 maternal deaths and 15 were in the nonmaternal deaths, discarding 38 incomplete reports. However, as we processed the data, it became obvious that *weight* was omitted on an equal number of records.

Herewith, the Committee presents three (grotesque) "*high risk*" cases representing death due to hemorrhage, infection, and toxemia, respectively. Quite obviously, *obesity* contributed a fatal deluge to other impending problems.

## Case No. 1046

This was a 39-year-old, black, para VII, abortus I, who died 31½ hours postpartum. Her past history included latent, early syphilis treated with penicillin, and toxemias with previous pregnancies. There was one abortion with a dilation and curettement, one previous term pregnancy delivered a stillborn, large fetus, while the other five pregnancies all delivered huge babies (range 3.6 kg [8 lb] to 4.5 kg [10 lb]) without complication. The patient was ALWAYS obese, weight ranging ABOVE 203.5 kg (430 lb). A glucose tolerance test revealed only a "low threshold."

Classified as a "*high risk*" obstetric patient in her third month, the patient registered with her last pregnancy, which was complicated by albuminuria and edema in the 35th week; she required hospitalization, diet, bed rest, and diuretics. After six days, the patient had lost 5.9 kg (13 lb) and her blood pressure, which had been elevated, stabilized at 140/100 mm Hg. She was dis-

charged undelivered, August 20, to be seen at weekly intervals in the clinic. At 38 weeks, she cancelled her appointment . . . "too sick to come in." Although the patient claimed "no fetal movement" (no fetal heart beat was audible), an x-ray film of the abdomen failed to confirm fetal death. She was admitted September 6th (39 weeks) with mild vaginal bleeding, presenting part high, a breech, membranes bulging.

Labor began irregularly, membranes ruptured spontaneously at 10 AM, and due to "deep veins," an intravenous Pitocin injection was not started. Labor was of a desultory type. Blood pressure varied from 120 to 160 mm Hg systolic over 50 to 88 mm Hg diastolic; no fetal heart sounds were elicited. The cervix had reached full dilation by 7 PM. In the delivery room, under cyclopropane anesthesia, a foot prolapsed spontaneously; maceration was observed. Moderate traction delivered the fetus to the umbilicus. The aftercoming head became "fixed in the pelvis"; a futile attempt was made to apply aftercoming head forceps; there was insufficient room between the fetal head and sidewalls of the vagina. Finally, the head was delivered by the Mauriceau-Smellie-Veit maneuver; the stillborn infant weighed 3030 gm. The third stage was reported normal. Manual examination revealed "an eight to nine cm posterior laceration, thought to be in the cul-de-sac." An attempt at visualization of the laceration proved impossible due to the extreme obesity of the patient. Two cutdowns allowed for parenteral fluids and blood administration. Under cyclopropane anesthesia, a laparotomy was performed while blood pressure was falling. Approximately 2000 ml of blood was present in the peritoneal cavity, and a laceration was discovered in the posterior aspect of the lower segment. During a prompt, supracervical hysterectomy, cardiac arrest developed. External cardiac massage was instituted; the "crash team" arrived. Cardiac massage, calcium, Wyamine, Levophed, sodium bicarbonate, Isuprel, Solu-Cortef, and ether were administered during the ensuing hour, together with seven units of whole blood. Estimated blood loss was 4,500 to 5,000 ml; replacement 5,000 ml. The patient followed a progressive downhill clinical course, and in spite of intensive therapy, she died at 10:00 PM on September 6th.

*Cause of Death (Autopsy):* Hemorrhage, hemoperitoneum, due to ruptured uterus; therapeutic misadventure, breech extraction of stillborn, term fetus; cardiac arrest during subtotal hysterectomy; obesity, exogenous, severe; toxemia of pregnancy.

## Comment

With sympathetic astonishment, the Committee reviewed facts presented in this case, appreciating completeness with which the report was written. Several members believed a destructive operation should have been performed upon the fetus;

\*A continuous statewide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

†Obesity: criteria defined in *Guiding Principles for Obstetric Care*.<sup>1</sup>

one felt that the internal iliac arteries should have been ligated during the surgical procedure. Obviously, all agreed that the "high risk" patient should have not become pregnant the last time. After a thorough discussion (by a narrow vote), the case was voted a *preventable* maternal death.

### Case No. 718

This patient was a 36-year-old, "high risk," white, gravida XIII, para IX, abortus III, who died undelivered at term. For years she had been *obese* and had had *hypertension*; a *huge* umbilical hernia had ulcerated during the past 17 years. There were nine previous term pregnancies, one stillborn (due to prenatal measles); the last term pregnancy terminated in a two-day labor, breech delivery five years ago. She had had transient hypertension (?) but was *never* specifically treated for it. On January 23, the patient registered with her physician, in the 28th week of pregnancy, by history. Examination revealed a huge patient weighing well over 157.5 kg (350 lb) with a large pendulous, abdominal apron draped to the knees, containing an immense, ulcerated, umbilical hernia. Fetal heart tones were not elicited but the patient volunteered presence of fetal movement; a moderate amount of milky leukorrhea was present on vaginal examination. Her pulse was 80 beats per minute, blood pressure was 170/100 mm Hg; the blood type was B+; and the result of serology test was negative. Anticipating possible problems, the physician made unsuccessful attempts to persuade the patient to go to a not-too-distant medical center for subsequent care and delivery; she refused. Advised to return in a week, the patient came for reexamination in *two* weeks; urine sample was not obtainable. The blood pressure was 160/80 mm Hg. Two days later (at term), on February 15, the patient appeared for admission with her membranes ruptured 48 hours, in early labor several hours. Urine was not obtainable; hemogram was normal; blood urea nitrogen value was 10 mg per 100 ml; blood glucose (fasting) level was 100 mg per 100 ml. Sterile vaginal examination revealed free amniotic fluid, a thick cervix, 4 cm dilated, presenting breech at -1 station. X-ray film of the abdomen was technically inadequate. Procaine penicillin, 600,000 units, was given intramuscularly every six hours. Labor was desultory, accelerated by a well-controlled Pitocin drip for two hours; meconium appeared; labor was still irregular at 2 PM. At 4 PM, temperature was 36.7 C (98 F), pulse 80 beats per minute, blood pressure 150/80 mm Hg, and fetal heart sounds 156 per minute. A cesarean section was entertained but rejected due to the huge hernia and extreme obesity.

Four hours later, the patient became febrile, but slept most of the night. Irregular contractions began again February 16, and by 8 PM, the blood pressure was 230/130 mm Hg. Sodium phenobarbital and magnesium sulfate were given intramuscularly with Diuril given by mouth; a catheterized sample of urine was negative. By midnight, February 16, the blood pressure diminished to 148/80 mm Hg. Morphine sulfate, 1/4 grain (15 mg), was given twice for rest. On February 17, phenobarbital magnesium sulfate injections were repeated, and by 7 PM, the cervix was 8 cm dilated, 50 percent effaced, temperature was 40.0 C (104 F), blood pressure was 140/180 mm Hg, and there was a mottled cyanosis of both lower extremities. Labor was irregular.

Streptomycin, Gantrisin, and Achromycin were administered. By 10 PM on February 17, the presenting part was at station +1, the cervix 8 cm dilated and thin. The patient received morphine sulfate, 1/4 grain (15 mg). Half an hour later, temperature was 37.9 C (100.2 F), blood pressure 104/60 mm Hg, and pulse 100 beats per minute. Shortly after, there was a loud "slushing sound" like water slopping back and forth in a container; the patient looked surprised, became dyspnoic, cyanotic, had a clonic convulsion, and ceased breathing.

*Cause of Death (Autopsy):* Pregnancy at term, labor (fetus over 5000 gm) undelivered; exogenous obesity; essential hypertension; preeclampsia; septicemia,

secondary to endometritis; pulmonary embolism; huge, ulcerated, umbilical hernia; cholelithiasis.

### Comment

With intense interest, the Committee studied available facts in the report commending the attending physicians for an "excellent workup." Lack of appearance for prenatal care was considered, as well as her failure to follow physicians' advice to continue care at a well-equipped medical center. Extreme obesity, essential hypertension, and an incarcerating (huge) umbilical hernia most certainly placed the patient in a "high risk" category! Once admitted with ruptured membranes (48 hours), in labor, the pattern was set! Members felt that larger doses of antihypertensive, diuretic, and antibiotic medications might have been employed sooner. Rejection of a cesarean operation (early) seemed feasible, but members wondered if a surgical delivery would have been done earlier, had the patient been in "the medical center." The committee voted this a *preventable* maternal death.

### Case No. 1257

This 35-year-old, "high risk," black, para IV, cesarean I, died two hours postoperative. Her past history involved a *cardiac* arrhythmia (17 years before), *syphilis* treated, and toxemias with all previous pregnancies; these were term gestations without other complications. She was *obese* for years, weighing from 113.5 kg (250 lb) to 122.6 kg (270 lb). In 1965, she had a thyroidectomy. She first visited a clinic at 31 weeks, with preeclampsia. The initial blood pressure was 155/100 mm Hg, later rising to 190/130 mm Hg; the urine had 10 gm per 100 ml protein, and edema was 2+. Diuretics and a low sodium diet were prescribed. In her 35th week, she developed persistent headaches, blurred vision, and a weight gain of 45.9 kg (10 lb) in two weeks. On February 21 (38 weeks), she was admitted with blood pressure 190/130 mm Hg, proteinuria 3+, edema 2+, and uterine pregnancy term size. The abdomen was huge and pendulous. The electrocardiogram revealed sinus arrhythmia with atrial hypertrophy and dilatation. A strict medical regimen of therapy was followed by transient improvement. However, since the blood pressure soared to 250/110 mm Hg and the patient's condition seemed to worsen, a decision to induce labor was made. The induction was unsuccessful, with some dystocia present. Hence, on February 24, a cesarean section was performed (general anesthesia) delivering a 3.6-kg (8-lb), living baby; the delivery was followed by a total abdominal hysterectomy and bilateral salpingo-oophorectomy (bilateral, "malignant-looking," ovarian cystic tumors, pathologist's diagnosis: luteoma). Postoperative condition was "fair"; blood pressure was 160/100 mm Hg, and two units of blood were replaced. Blood pressure elevated to 100 to 240/120 to 140 mm Hg, and after two hours, pulmonary edema gradually developed; cardiac arrest occurred suddenly and all heroic measures were of no avail. Death was pronounced.

*Cause of Death (Autopsy):* Cardiac arrest; acute pulmonary edema; essential hypertension with toxemia; cardiomegaly; bilateral ovarian cysts; exogenous obesity; pregnancy, term, delivered by cesarean section (with bilateral salpingo-oophorectomy).

### Comment

Members of the Committee carefully studied and evaluated the complete details in this case

report. The exact nature and severity of the patient's "cardiac history" seemed indefinite. Obviously, she should have had early, concentrated, prenatal care. When induction of labor failed, a cesarean section was the only alternative for delivery in spite of a risk; however, members discussed the extension of the surgical procedure in view of the patient's critical condition. The Committee voted this a *preventable* maternal death.

#### Comment of Consultant

The following comment of a consultant specializing in obstetrics and gynecology was furnished at the request of the Committee.

"These remarks will be brief since the devastating pathology in each of the three cases cited has been subjected to excellent comment by the Committee.

"*Case No. 1046*: A real difficult case! I agree with the last comment.

"*Case No. 718*: Obviously, the patient should have been managed in a 'medical center.' However, although this was not available, I doubt that

the outcome would have been altered, had the patient been transferred.

"*Case No. 1257*: This case is a little different, clouded by a murky history of hypertension and 'cardiac disease.' I would have advised early hospitalization and prolonged intensive care of the cardiovascular disease.

"In summary, I would conclude that much more attention must be focused upon the 'protective care' of the *obese obstetric patient*."

#### Generic and Trade Names of Drugs

Oxytocin injection — Pitocin (Parke-Davis)  
Mephentermine — Wyamine Sulphate Injection (Wyeth)  
Levarterenol bitartrate — Levophed (Winthrop)  
Isoproterenol — Isuprel (Winthrop)  
Hydrocortisone sodium succinate — Solu-Cortef (Upjohn)  
Sodium chlorothiazide — Diurel (Merck Sharp & Dohme)  
Sulfisoxazole diolamine — Gantrisin (Roche)  
Tetracycline HCl — Achromycin (Lederle)

#### Reference

1. Guiding principles for obstetric care. *Ohio State Med J* 53:1328-1329, 1957, (revised 1963 and 1972, reprinted, not published).

## Discussion of The E.N.T. Case of the Month

(continued from p. 903)

The red, weeping, excoriated appearance of the skin of the ear canal and auricle has the typical appearance of an acute contact dermatitis. An accurate history is, perhaps, the most important facet in diagnosing the exact etiology of this lesion. This particular patient had been using a new hair spray, which proved to be the allergic agent.

Poison ivy, oak, metal compounds, cosmetics, and topical medications also are common contact allergens.

Treatment consists of first removing the offending allergen. The acute weeping stage may be treated with Burows soaks (aluminum acetate 1:20) applied to the ear. Later, topical corticosteroids may be used to control the itching and scaling appearance of the skin that will occur.



# Professional Activities



## Proceedings of The Council

Meeting of September 29-30, 1973

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, September 29-30, 1973, at White Sulphur Springs, West Virginia.

Those present Saturday were: All members of the Council, except Dr. James C. McLarnan; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Mrs. Wisse, Mr. Moore and Mrs. Dodson, of the OSMA staff.

Those present Sunday were: All members of the Council, except Dr. Richard E. Hartle and Dr. McLarnan; Mr. Pohlman and all members of the OSMA staff.

### Minutes Approved

Minutes of the meeting of July 14-15 were approved.

### Building Committee

Minutes of the Building Committee meeting of July 15, 1973, were presented by Mrs. Wisse and were approved.

### Membership

Membership statistics were presented by Mrs. Wisse, indicating a gain in OSMA members over December 31, 1972, and a gain in AMA members over September 29, 1972.

### American Medical Association

Mr. Campbell announced that Dr. Meiling would serve as chairman of Reference Committee E at the AMA Clinical Meeting, and that Dr.

Osgood would serve on Reference Committee B.

The Council voted to submit as a candidate for the Dr. Benjamin Rush Bicentennial Award for Citizenship and Community Service of the American Medical Association, Esther C. Marting, M.D., Cincinnati, Ohio.

The Council voted to support the following candidates for AMA appointments:

**Council on Scientific Assembly** — John E. Albers, M.D., Cincinnati and Frances K. Harding, M.D., Columbus.

**Committee on Maternal and Child Care** — Richard T. F. Schmidt, M.D., Cincinnati.

**Committee on Transfusion and Transplantation** — Mary M. Martin, M.D., Cincinnati.

**Council on Mental Health** — Viola V. Startzman, M.D., Wooster and Edward O. Harper, M.D., Cleveland.

**Committee on Exercise and Physical Fitness** — Emily R. Hess, M.D., Cincinnati.

**Committee on Health Care of the Poor** — Esther C. Marting, M.D., Cincinnati.

**Archives of Internal Medicine** — Earl N. Metz, M.D., Worthington.

**Committee on Medical Aspects of Sports** — Robert J. Murphy, M.D., Columbus.

### Committee Reports

#### Committee on School Health

Minutes of the meeting of the Committee on School Health of July 18 were presented by Mr. Clinger, and were approved by the Council.

Approval of the minutes included approval of the committee's recommendation that OSMA

oppose H.B. 961, requiring courses in VD education for grades 7 through 12. The committee's comment was that "Venereal Disease education should be part of a comprehensive health education curriculum rather than a single, crisis-oriented unit."

Also **approved**, was the committee's offer of its services to the State Department of Education to help delineate educational requirements for nurses in order for them to meet certification standards to comply with the new law created by Sub. H.B. 341 (to certify school nurses).

Also **approved**, was the committee's recommendation that the AMA be urged to again publish the book "Today's Health Guide."

The committee's suggestion that the Ohio Director of Health and the State Superintendent of Public Instruction be contacted with regard to the need for statistics and the outlining of the lack of enforcement of the immunization laws in the schools **was approved**.

The minutes, as a whole, **were approved**.

#### **Commission on Medical Education**

Minutes of the meeting of the Commission on Medical Education of July 25 were presented by Mr. Edgar. The Council asked the Commission to proceed with its direction from the House of Delegates to develop plans for continuing medical education recognition rather than to re-survey Ohio physicians regarding current continuing medical education involvements.

#### **OSMA Scientific Sections and Specialty Society Representatives**

Minutes of the OSMA Scientific Sections and Specialty Society Representatives of July 25 were presented by Mrs. Dodson and were accepted for information by the Council.

#### **Committee on Scientific Work**

Minutes of the meeting of the Committee on Scientific Work of August 1 were presented by Mrs. Dodson. The theme of the 1974 Annual Meeting, "Cycles of Life and Health" **was ratified** by the Council.

With regard to Annual Meeting speakers who are Ohioans, the Council asked that such speakers be appropriately recognized. An honorarium, the Council stated, is not feasible at this time due to budget limitations.

The suggestion of the committee that the membership of the Association be polled with regard to their preferences for scientific programs **was approved**.

The format of the meeting, as outlined by the committee, **was ratified**, as were the post-graduate courses established by the committee.

A daily news bulletin for those attending the convention received the approval of the Council,

as did the criteria for the 1974 Physicians' Art Exhibit.

The Council **approved** a social function to be held at the Frederick C. Crawford Auto-Aviation Museum, with a catered dinner and bar, and a dance orchestra featuring music of the 30's and the 40's.

The Council **approved**, item by item, suggestions of the committee with regard to the Exhibit Hall and the conduct of the commercial and scientific exhibits. The Council asked the committee to communicate with appropriate allied health organizations, requesting that they grant an award to scientific exhibitors similar to the one sponsored by the Ohio Chapter of the American Cancer Society.

A third category was added to the Scientific Exhibit Awards. The new category is Clinical Investigation. The new category is to be placed on the Scientific Exhibit Application along with the Scientific Exhibit categories of Teaching and Original Research.

The minutes, as a whole, as amended, **were approved**.

#### **Medical Advisory Committee to Nationwide**

Minutes of the meeting of the Medical Advisory Committee to Nationwide of August 8 were presented by Mr. Gillen and **were approved**.

The Council **approved** the filing of a communication with Paul S. Metzger, M.D., Vice President of Medical Affairs of Nationwide Insurance Company, and one to the Bureau of Health Insurance, offering the services of physicians to provide input and direction at the regional and national levels of that agency.

#### **Subcommittee on Insurance Coverage for Scholastic Athletes**

Minutes of the meeting of the Subcommittee on Insurance Coverage for Scholastic Athletes of August 15 were presented by Mr. Clinger, and **were accepted** for information.

#### **Committee on Membership and Planning**

Minutes of the meeting of the Committee on Membership and Planning of August 22 were presented by Mr. Gillen. The Council authorized the committee to conduct studies on how to improve the economic status of The Journal. The committee was also authorized to make arrangements with an advertising representative in order to increase the amount of "local" advertising.

The minutes **were approved** as amended.

#### **Committee on Podiatry Relations**

Minutes of the meeting of the Committee on Podiatry Relations of September 19 were presented by Mr. Rader and **were accepted** for information.

*(Continued on Next Page)*

## Committee on Nursing

It was the decision of the Council that the Committee on Nursing remain as one of the special committees of the Ohio State Medical Association.

## Health Manpower Committee

The Council voted to establish a Committee on Health Manpower, effective immediately.

## Direct Billing

The Council voted to reaffirm the OSMA policy with regard to direct billing and instructed that statements be published in the next six *OSMAgrams* to bring the importance of direct billing to the membership. In addition, special articles in *The Ohio State Medical Journal* and a communication from the President to the county medical societies were authorized by the Council.

## Complaint Procedures

The Council expressed the need for improvement in the handling of complaints with regard to medical care services and health care services. The President was authorized to establish an Ad Hoc Committee to completely review the OSMA complaint procedures and relationship of these procedures to that of Medical Advances Institute-PSRO. The President named Dr. Schultz as chairman and Drs. Lieber and Morgan as members of the committee.

## Ohio Medical Indemnity

The OMI Liaison Committee report was presented by Dr. Schultz.

## Governor's Task Force

Dr. Schultz reported on the September 20 meeting of the Organization Committee of the Governor's Task Force on Health Care. The Council voted to thank Dr. Schultz for his work on the Task Force and for his statement of September 20, 1973 to the Task Force Committee.

## Amalgamated Clothing Workers

Dr. Clarke reported on a conference with Sol J. Benensohn, M.D., Medical Director of the Sidney Hillman Health Centre of Chicago, with regard to the extension of the diagnostic medical plan of the Amalgamated Clothing Workers of America to Ohio.

Dr. Benensohn pointed out at the conference that the principle of this program is to maintain the patient-doctor relationship between the member of the union and the doctor of his choice. He

said that in the program previously arranged fees are paid directly to the physician for his services. The report was received for information.

## Certificate of Need

The Council received for information a document from John W. Cashman, M.D., Ohio Director of Health, regarding review procedures for Public Law 92-603, Section 221 "Capital Need Limitations." In addition, the Council was given for information staff comments made at an informal hearing on Certificate of Need conducted by Dr. Cashman on August 10, 1973, as developed by Mr. Rader.

Mr. Rader also presented his report on the Ohio Insurance Commissioner's Proposed Rule IN-1739-01, "Certificate of Need," and his testimony before the commissioner's public hearing on August 28, 1973.

The above reports were accepted for information by the Council.

## Medicare

A communication from A. Robert Davies, M.D., Secretary of the Miami County Medical Society, to Dr. Clarke, regarding the Ohio Medicaid program was accepted for information.

## State Lodges and Recreational Facilities

The problem of the availability of medical care at the various state-owned lodges and other recreational facilities was discussed by the Council and the problem was referred to the Emergency Medical Services Committee for study and report.

## Ohio State Medical Board

President Clarke was authorized by the Council to confer with the President of the Ohio State Medical Board, with regard to several problems brought to the attention of the Council by members of the Association.

## Councilor Reports

The Councilors reported on activities in their respective districts.

## Ethics Question

Dr. Thomas reported on his investigation of an ethics matter in Huron County brought to the attention of the Council by the Ohio State Pharmaceutical Association. The report was received for information.

*(Continued on Page 919)*



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Each pink tablet in Demulen-28® is a placebo, containing no active ingredients.

**Actions**—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

**Special note**—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

**Indication**—Ovulen and Demulen are indicated for oral contraception.

**Contraindications**—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

**Warnings**—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain<sup>1-3</sup> leading to this conclusion, and one<sup>4</sup> in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll<sup>3</sup> was about sevenfold, while Sartwell and associates<sup>4</sup> in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as non-users. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

**Precautions**—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of

fluid retention, conditions which might be influenced by this factor such as epilepsy, migraine, asthma, cardiac or renal dysfunction require careful observation. In breakthrough bleeding, and in a cases of irregular bleeding per vaginam, nonfunctional cause should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

**Adverse reactions observed in patients receiving oral contraceptives**—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast change (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T<sub>3</sub> take values; metyrapone test and pregnanediol determination.

**References:** 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. 2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Br. Med. J. 2:193-199 (April 27) 1968. 3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-6 (June 14) 1969. 4. Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Gree, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidemiol. 90:365-380 (Nov.) 1969.

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**Indication**—Enovid-E is indicated for oral contraception.

The Special Note, Contraindications, Warnings, Precautions, Adverse Reactions listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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Where "The Pill" Began

*(Proceedings of The Council—Contd.)*

### Ohio Foundation for Medical Care

A report on the recent incorporation of the Ohio Foundation for Medical Care was presented by Mr. Gillen. The President asked the Council to submit to the Executive Director names of persons for possible appointment to the Board of Trustees of the Ohio Foundation for Medical Care. The report was accepted for information.

The Council then convened in Executive Session.

### Executive Session

With regard to a request from Medical Advances Institute to obtain the full-time services of Herbert E. Gillen, the Council agreed to provide the services of Mr. Gillen in accordance with a contract outlined by OSMA Legal Counsel, on a year-to-year basis, with termination provisions on a mutually agreeable basis. It was decided that Mr. Gillen should remain as an employee of the Ohio State Medical Association and that Medical Advances Institute should reimburse the Ohio State Medical Association for his services pursuant to the proposed contract.

The Council **approved** the hiring of Douglas R. Houser, Columbus, Ohio, as a member of the OSMA Executive Staff, beginning October 23, 1973.

The Executive Session adjourned and the Council reconvened.

### Duties of the Councilors

President Clarke directed the attention of the Council to Chapter 7, Section 1, of the OSMA Constitution and Bylaws with regard to duties and responsibilities of the Councilors.

### PSRO Council

Minutes of the August 26 meeting of the PSRO Council were presented by Mr. Gillen and were received for information.

Many of the Councilors expressed the need for continued unity of the county medical societies and the PSRO implementation which will become a federal requirement in 1974.

The President instructed Stephen P. Hogg, M.D., and George D. J. Griffin, M.D., of Cincinnati, to submit in writing their concept of Professional Standards Review Organization, and Robert R. Clark, M.D., Akron, and James L. Henry, M.D., to do likewise, in order that the Council may resolve any differences in the respective concepts. The papers will be reviewed by the following subcommittee, Drs. Gaughan, Bates and Thomas, before Council considers and acts upon the recommendations of the subcommittee.

The Council Meeting was then adjourned.

ATTEST: Hart F. Page  
*Executive Director*



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# Medical Board Policy on Physicians' Assistants

In response to an inquiry from a County Medical Society executive secretary, William J. Lee, Administrator of the State Medical Board of Ohio, gave the following information on what the present Ohio Revised Code provides in regard to employment of a physician's assistant and what the Board policy is on such employment.

Please be advised that Section 4731.34, Revised Code, provides in part as follows:

A person shall be regarded as practicing medicine, surgery, podiatry, or midwifery, within the meaning of sections 4731.01 to 4731.60, inclusive, of the Revised Code, who uses the words or letters, "Dr.," "Doctor," "Professor," "M.D.," "D.S.C.," "Pod.D.," "M.B.," or any other title in connection with his name which in any way represents him as engaged in the practice of medicine, surgery, podiatry, or midwifery, in any of its branches, or who examines or diagnoses for compensation of any kind, or prescribes, advises, recommends, administers, or dispenses for compensation of any kind, direct or indirect, a drug or medicine, appliance, mold or cast, application, operation, or treatment, of whatever nature, for the cure or relief of a wound, fracture or bodily injury, infirmity or disease. \*\*\*\* (Emphasis added.)

Section 4731.41, Revised Code, provides in part as follows:

No person shall practice medicine or surgery, or any of its branches without a certificate from the State Medical Board; no person shall advertise or announce himself as a practitioner of medicine or surgery, or any of its branches, without a certificate from the board; no person not being a licensee shall open or conduct an office or other place for such practice without a certificate from the board; no person shall conduct an office in the name of some person who has a certificate to practice medicine or surgery, or any of its branches. \*\*\*\*

All unlicensed persons including Physicians' Assistants and Paramedics are persons prohibited from practicing medicine and surgery by the provisions of sections 4731.34 and 4731.41, Revised Code, as stated aforesaid. Such persons shall not admit anyone to a hospital or release anyone from a hospital, shall not diagnose or treat, and shall not prescribe drugs.

Fully licensed physicians employing unlicensed persons to assist them are responsible for making certain that such persons are not practicing medicine and surgery and that services performed by such persons are performed in the immediate presence of and under the direct supervision of such fully licensed physicians.

Please be advised that the State Medical Board presently has under consideration proposed position papers concerning physicians' assistants and paramedics.



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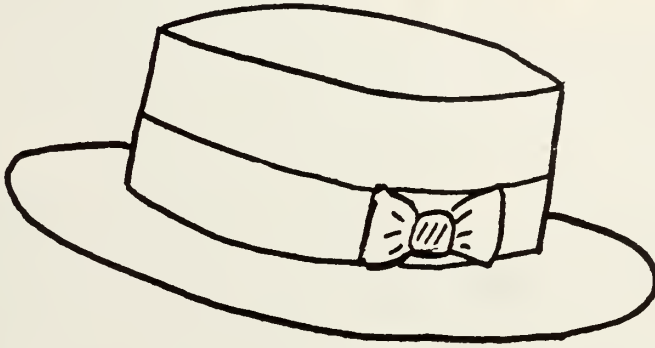
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A copy of our report, filed with the appropriate supervisory officer is (or will be) available for purchase from the Superintendent of Documents, United States Government Printing Office, Washington, D. C. 20402.

# Obituaries

**Vincent Ambrose Aufderheide, M.D.**, Dayton; St. Louis University School of Medicine, 1936; aged 63; died October 18 while vacationing in Greece; member of OSMA and AMA; general practitioner of long standing in Dayton; veteran of World War II.

**Thomas Hart Borland, M.D.**, Cleveland; University of Toronto Faculty of Medicine, 1924; aged 72; died October 23; member of OSMA, AMA, and American Academy of Family Physicians; practitioner of long standing in Cleveland. Among survivors is a son, Dr. Thomas R. Borland.

**Robert Alexander Breckenridge, M.D.**, Cuyahoga Falls; Queen's University Faculty of Medicine, 1927; aged 70; died October 24; member of OSMA, AMA, American Academy of Family Physicians, and Aerospace Medical Association; practitioner for some 45 years in the Cuyahoga Falls area; veteran of World War II. Among survivors is a son, Dr. Robert T. Breckenridge, of Rochester, N. Y.

**James W. Cass, M.D.**, Sylvania; Toledo Medical College, 1912; aged 91; died October 17; former member of OSMA; private practitioner many years ago in Farmer and in Toledo; from 1922 until his retirement in 1952, associated with

the Veterans Administration, mostly in the Toledo office.

**Paul Denton Espey, M.D.**, Quincy, Illinois; Medical College of Ohio at Cincinnati, 1905; aged 93; died October 2; member of OSMA and AMA; practitioner of long standing in Xenia, before his retirement in 1966. Among survivors are two physician sons, Dr. Hugh S., of Quincy, and Dr. Frank F., of Greenville, S. C.

**Edward Alphonse Grad, Sr., M.D.**, Cincinnati; Eclectic Medical College, Cincinnati, 1921; aged 85; died October 25; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner and general surgeon in Cincinnati for more than 50 years. Among survivors are a daughter, Marjorie A. Grad, M.D., and a son, Edward A. Grad, Jr., M.D., both of Cincinnati.

**Albert Aloysius Hill, M.D.**, Cleveland; St. Louis University School of Medicine, 1927; aged 76; died October 3; member of OSMA and AMA; Fellow, American College of Cardiology; practitioner of long standing, mostly in the Brooklyn area of Greater Cleveland, where he specialized in cardiology.

**James Ralph Mack, M.D.**, Cincinnati; Harvard Medical School, 1933; aged 66; died October

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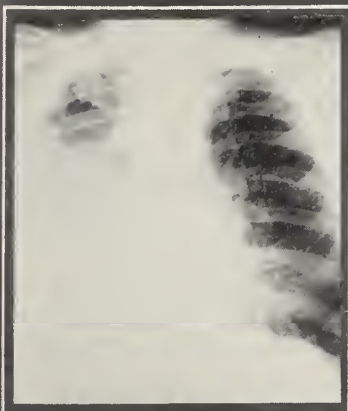
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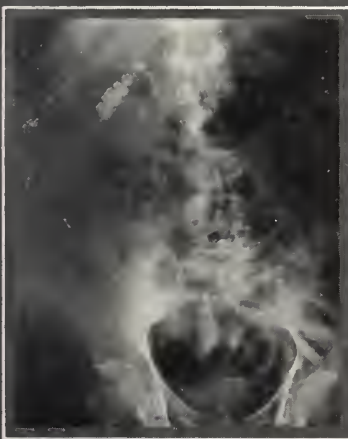
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14; member of OSMA, AMA, and the Central Surgical Association; Fellow, American College of Surgeons; past president of the Cincinnati Surgical Society; practitioner of long standing in Cincinnati; veteran of World War II.

**Donald W. McIntyre, M.D.,** Jupiter, Fla.; Western Reserve University School of Medicine, 1928; aged 69; died September 16; member of OSMA, AMA, and the American Urological Association; Fellow, American College of Surgeons; diplomate, American Board of Urology; practitioner for many years in Cleveland, where he specialized in urology; living in retirement in recent years.

**Henry Kuykendell Montgomery, M.D.,** Dayton; University of Arkansas School of Medicine, 1936; aged 65; died October 22; member of OSMA, AMA, and Industrial Medical Association; industrial practitioner, associated with the Frigidaire Company in Dayton for about 35 years; veteran of World War II.

**John Albert Murphy, M.D.,** Cleveland; Western Reserve University School of Medicine, 1934; aged 64; died October 6; member of OSMA, AMA, American Academy of Orthopaedic Surgery; Fellow, American College of Surgeons; diplomate, American Board of Orthopaedic Surgery; practicing surgeon in Cleveland for some 40 years.

**Pawlo Warlaan Pastuchiw, M.D.,** Lorain; native of the Ukraine who received his medical degree in Europe and practiced there until the early 1940's, died October 6 in Lorain where he was making his home in retirement. His son, Dr. Paul Pastuchiw, practices in Lorain.

**George Merritt Stroud, M.D.,** Indiatlantic, Fla.; Duke University School of Medicine, 1938; aged 58; died September 18; former member of OSMA; former practitioner in Cleveland where he specialized in dermatology.

**Carl Henry Wendel, M.D.,** Cincinnati Eclectic Medical College, Cincinnati, 1927; aged 71; died October 24; member of OSMA and AMA; general practitioner of long standing in Cincinnati; formerly practiced in association with his father, the late Dr. Henry C. Wendel.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during October. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

|  |  |
|--|--|
| <b>CLERMONT</b><br>Jack M. Gniwesch<br>Cincinnati  | Shahin E. Tabatabai<br>Cedomil F. Vugrincic<br>James V. Zelch  |
| <b>COLUMBIANA</b><br>Fu-Nen Lee<br>Salem<br>Antonio S. Soriano<br>Salem<br>Jiunn- Chang Tzeng<br>Salem   | <b>FRANKLIN</b><br>H. T. Villavecera<br>Westerville<br>Hagop S. Mekhjian<br>Columbus   |
| <b>CUYAHOGA (Cleveland)</b><br>Antonio DelaRosa Abella<br>Muzaffar Ahmad<br>L. Amarnath<br>Liwanag A. Asuncion<br>Rais A. Beg<br>Jean R. Berggren<br>Garnett S. Best<br>Glenda W. Brodkey<br>Phanga E. Cheanvechi<br>Thomas P. Cliffl<br>Robert A. Danielson<br>Leonardo S. Del Rosario<br>Mario M. Demesa, Jr.<br>Gerhard M. Doerr<br>Douglas W. Eastwood<br>Kay E. Frank<br>Michael J. Freeman<br>Claudio Gallo-Godoy<br>Harilal G. Gatha<br>Faustino Gomez<br>Peter D. Gomos<br>Philip M. Hall<br>Keith R. Koepke<br>Magnus O. Magnusson<br>Mark A. Mandel<br>Ronald L. Mattlin<br>Melvin S. Rosenthal<br>Virgilio D. Salanga | <b>HAMILTON</b><br>Carmencita Rimando-Jose<br>Cincinnati   |
|  | <b>LUCAS</b><br>Alex R. Dubin<br>Toledo  |
|  | <b>MARION</b><br>Samuel V. Lardizabal<br>Marion  |
|  | <b>MONTGOMERY (Dayton)</b><br>Gerald R. Abel<br>Emil Gutman<br>Jeffrey A. Horwitz<br>Huascar E. Jessen<br>Robert J. Kuchlewski<br>Asuncion V. Medina<br>Juan A. Paulet<br>James F. Romer<br>Donald P. Sickler<br>William T. Stalter<br>John G. Wagnitz<br>Almira U. Yusi |
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# Ohio's Four Medical Colleges Received More Than \$42,000 from AMA-ERF This Year

OHIO'S ANNUAL CAMPAIGN on behalf of the American Medical Association Education and Research Foundation is now under way to make it possible for Medical Education Loan Guarantee Programs. Dr. Philip Hardyman, Columbus, is chairman of the Ohio AMA-ERF Committee, which includes councilors of the 11 Councilor Districts of the Ohio State Medical Association.



Philip Hardyman, M.D.

Before launching Ohio's 1973 Annual AMA-ERF campaign drive for funds for Medical Education Loan Guarantee Programs, it might be well to quote a few facts which will be of interest to you.

"The total grants distributed to medical schools through the end of the 1972 contributions is \$23,743,233."

"For the period March, 1962 through December, 1972 a total of 48,700 loans have been made. The total dollar amount is \$55,334,775."

"The four medical schools in Ohio received \$42,214.65 from AMA-ERF in 1973 as follows:

"Case Western Reserve University School of Medicine — \$8,542.22

"Ohio State University College of Medicine — \$14,362.08

"The University of Cincinnati College of Medicine — \$15,778.79

"The Medical College of Ohio at Toledo — \$3,531.56."

All this has been done by the private sector of the economy without government subsidy. This

is an enviable record which can be maintained with the help of Ohio physicians.

But first, here are answers to some questions which you may have concerning the Student Loan Guarantee Fund.

Did you know: That through the Student Loan Guarantee Fund, the struggling medical student may receive direct financial aid?

Did you know: That it now costs at least \$5,000 per year to attend medical school?

Did you know: That your contribution to the Student Loan Guarantee Fund will be held as a guarantee for repayment of loans? For each \$1.00 you give, another \$12.50 will be put to work in loans made by a commercial bank, and as these loans are repaid the money is reactivated to help other students.

Did you know: That the accepted applicant becomes eligible for medical education loans of up to \$1,500 a year? Additional applications may be approved each year so that a maximum of \$10,000 can be borrowed over a seven year period.

Did you know: That since the inception of the Student Loan Guarantee Fund in 1962, 1,868 loans have been made to Ohio medical students for a total of \$2,057,350?

Did you know: That the borrower pays only the established interest rate during his training, and has ten years after completion of training to repay the principal?

The facts stated above are very impressive and the AMA-ERF student loan program has been designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine by utilizing the principal of a security fund functioning as a cosigning agency to make available through community banks relatively large sums of credit at a low rate of interest to medical students.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Hardyman and members of the Ohio AMA-ERF Committee urge, Ohio physicians to respond generously in this year's campaign.

YOU, Doctor, can be an important part of this program by contributing now. Where else can you buy so much for so little? Just think, a contribution of \$125 would guarantee a loan for a medical student for one year. Think about it!!



# Woman's Auxiliary Highlights

By MRS. S. L. MELTZER, Publicity Chairman  
2442 Dorman Drive, Portsmouth 45662

**"IT IS WHEN YOU GIVE OF YOURSELF** that you truly give," said Kahlil Gibran, the Lebanese poet. I recall that quotation now as I present this column's "Woman In The News"—Mrs. Joseph M. Kaplan of Cleveland. Recently her Cuyahoga County auxiliary honored her in a surprise presentation of a bronze and walnut plaque which reads: "In recognition of Florence Kaplan—For your outstanding contributions to the Health Careers Program of the Woman's Auxiliary to the Academy of Medicine of Cleveland. . . . Henceforth let the Student Grants-In-Aid be known as the Florence Kaplan Awards. Presented October 1973. . . ."

Would you believe that one woman could, in the span of just five years, net for her auxiliary and the Grants-In-Aid program some \$35,000.00? Yet she has accomplished exactly that. Florence Kaplan came up with the idea of selling costume watches—not ordinary watches but unusual, attractive "conversation pieces". And the idea caught on—first in Cleveland and then throughout the state of Ohio and finally throughout the country. What reflects so beautifully on Mrs. Kaplan is the fact that she has shared her idea with auxiliaries everywhere and made possible the full cooperation of the New York company that, together with this remarkable auxiliary member, has made this whole program possible.

It was at the Fall luncheon of the Cuyahoga group that Mrs. Kaplan received her award. Held at the Westwood Country Club, it was the tradi-

tional annual occasion for recognizing new members and honoring the Auxiliary's past presidents. Guest speaker was John Hambrick, colorful anchor man on the Channel 5 Eyewitness News Team.

Referring back to the Grants-In-Aid project, Cuyahoga is now carrying 23 students either in schools of nursing or in universities and this is a full four-year program. Selection of applicants is based on need and grades. Sometimes in one year it has been necessary to screen as many as 300 to 400 applicants; sometimes the figure has been about 60. The grants assist students in the fields of nursing, practical nursing, medical technology and physical therapy.

How's that for playing Santa Claus all the year round? It is my privilege to know Florence Kaplan and I have seen her "in action." Along with her dedication as a doctor's wife, she possesses an uncanny sales ability, warmth, ingenuity and the determination to give help where help is needed. She's the kind of doctor's wife we like to brag about. . . .

## Zippping Around the State!

Butler County's late September meeting was a festive occasion at the home of the auxiliary's president, Mrs. Brady Randolph, in Hamilton. A social hour preceded the 11:30 a.m. Champagne Brunch. Mrs. Karl Ulicny, state president, was the honored guest. Mrs. Venita Kelly, prominent fashion co-ordinator from Cincinnati, highlighted

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## THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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the afternoon's program. The group is again sponsoring the AMA-ERF Christmas Card sale.

**Franklin County** is another of those auxiliaries with a terrific Nursing Scholarships project. Ten nursing students were recently given such scholarships to further their education. These were chosen from seventeen candidates who had been recommended by their schools and represent Mt. Carmel, Ohio State, Riverside and Grant.

The money is a gift; there is no requirement for repayment. The scholarships are granted on a yearly basis, starting with the student's second year in nursing. It was felt that after having finished one year, the students would have settled the question as to whether nursing was their desired career and would have indicated whether they could maintain a good academic standing. The Franklin group is also getting good help from the sale of those fabulous watches we mentioned earlier.

The September meeting was a "triple play"—a get-together with two other groups—Starling Ohio and the Auxiliary to the Columbus Dental Society. It was a twelve-thirty luncheon at Stouffer's University Inn. Guest speaker was Mrs. Harold Enarson of Ohio State University.

The October meeting, a luncheon at the Scioto Country Club, featured a style show by Alba Ski Hut, spotlighting ski, golf, and tennis apparel as well as evening-wear clothes. The program was arranged by Mrs. L. David Hall. Hostesses included: Mrs. William J. McCloud, Mrs. Robert Larrick and Mrs. Wesley Furste.

But the day's warmest and most effective "presentation" was the tribute paid to Mrs. F. M. Gallagher, Franklin County's oldest active charter member. Mrs. Gallagher is 94 years old, still lives alone and loves it! Her "recipe" for living: "I still look forward to each and every day." . . .

### More Over The State

The **Hamilton County** auxiliary has answered the challenge of the state's Community Health Services committee and its chairman, Mrs. Albert May, to cooperate with another approved community health organization. As a result, a committee called "Health Department Volunteers" has been formed—its aim to supply volunteers to several clinics and other activities operated by the Cincinnati Department of Health. The auxiliary has compiled a list of available volunteer jobs which include 15 job descriptions, the number of volunteers needed, the time required to fulfill the assignment, training and special requirements that might be needed, and the location of facilities where the volunteers would be utilized. This list was subsequently presented to the general membership of the auxiliary as well as to various church groups, PTA's and other interested people within the community.

So far 13 auxiliaries have volunteered their time and skills to the Health Department. They have worked as clerks and assistants in the department laboratory, assisted with preschool children in the playroom of General Hospital, manned the appointment desk at neighborhood clinics, assisted the clinics' nursing staff, undertook a price comparison study (checked prices and quality of merchandise in various parts of the city as well as the condition of the store), furnished transportation to and from medical facilities for medical indigents, taught maternal and child health care courses at neighborhood clinics, joined the department's Speakers' Bureau to promote prenatal educational courses and to seek contributions for layettes. They proved to be great companions for the elderly by helping them shop or by arranging for a visit with their physicians.

The "Health Department Volunteers" committee keeps the general membership informed about the jobs via newsletters which are detailed and informative. The budget allowed this committee has been donated to the new program.

### Busy — Busy — Busy

The **Lucas County** membership is all agog over the group's 1973-74 "theme"—The Whole Woman. "It doesn't seem possible such a feat could be accomplished in the span of one Auxiliary year," comments Mrs. Marion C. Anderson, publicity chairman, "but a valiant attempt is being made." And then she gives a peek into some of the programs: A famous White House personality; a search for inner-self through astrology; acting, poetry and music, especially prepared and written; a seminar dealing with today's values; two "extra events"—one a "help ease the January Blahs" and a bus and box lunch to a Fisher Theatre matinee; the annual bridge-luncheon and style show—and that's as much of a peek as we're going to allow for now! There's lots more. . . . Lucas has so many things going in the way of community programs and projects that I'll have to leave mention of those for another time!

The group's Fall luncheon and general meeting was held on October 9 at which Dr. Boris Nelson was the guest speaker. He is professor of Fine Arts at the University of Toledo and also is the music critic of the *Toledo Blade*.

### Mrs. Todd Visits Summit

Mrs. Malcolm C. Todd, wife of the President-Elect of the American Medical Association, made it quite a special day for the **Summit County** auxiliary in September. She was the honored guest of the local group, visiting Akron along with Dr. Todd who had been invited to speak before the Summit County Medical Society.

The "red carpet" treatment was in order of

course and included such activities as: A private tour of Stan Hywet Manor (the tour guide was auxiliary member Mrs. Leo Roszell who volunteers at the Manor each Friday); a small informal luncheon at the Cascade Club given by Mrs. J. Paul Sauvageot, editor of *MD's Wife*; a visit to Summit's Mobile Meals office; a reception and tea at the Woman's Club attended by the auxiliary's past presidents, executive and general board and the Mobile Meals task force; a seven o'clock cocktail hour and buffet by the medical society and then the address by Dr. Todd.

Mrs. Thomas M. Schlueter, the Summit auxiliary president, told me that she and her committee had all of two and one-half weeks in which to set up the day's activities for the soon-to-be First Lady!

*The Akron Beacon Journal's* Women's Editor did a tremendous feature story on Mrs. Todd (incidentally, the Todds are from Long Beach, California). To quote from the newspaper story: "When it comes to a variety of interests, few women can hold a candle to Ruth Todd. . . . She is active in programs for retarded children, is immediate past president of the board of directors of the Retarded Children's Foundation in Long

Beach, was named Long Beach's "woman of the year" in 1972 and received the 1967 Hannah Solomon Award from the National Council of Jewish Women for her service to handicapped children. She is a member of the Los Angeles Cancer Society Board of Directors and is on the boards of the Long Beach Symphony Association and Arts Council. Then there are other activities like the Community Epilepsy Clinic, the United Crusade, the Girl Scout Council and the YMCA."

And that isn't all! Mrs. Todd is also a regent for the California Lutheran College, chairman of the Long Beach Planning Commission, was area chairman for the 1970 U. S. census and is a past president of the Long Beach auxiliary. Mrs. Todd recently joined a new board—that of the General Telephone Company. "I was pleased when they asked me," she said, and added with a laugh, "I asked them if belonging to their board made me a ding-a-ling or a call girl." . . .

How does she do it??? Only an incredible woman could, and Ruth Todd obviously is all of that!

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Expansion of Occupational Health Program and pending retirement of two full time physicians create a need for two Board-qualified or certified Internists or Surgeons to deliver primary occupational health care in Cincinnati.

Additionally, a physician with private practice experience desiring regular hours and stable practice is needed to assist the Medical Director in monitoring present programs, and to develop new ones.

Industrial practice experience is desirable, but not a prerequisite. You would be joining a company noted for its stability and advanced industrial medical practices, and would be eligible for the program of employee benefits ranking among the top 5% of all U.S. companies, including profit-sharing and low-cost insurance.

To investigate these opportunities, send resume and salary requirement to Box 696, c/o Ohio State Medical Journal.

*An Equal Opportunity Employer*

### Physician Assistant

Editor's Note: The Journal presents the following classified advertisement to its readers as an announcement of the physician assistant and assumes no responsibility for the statements made.

**PHYSICIAN ASSISTANT — 27 y/o ex. Navy Corpsman, BS — Biology**, will graduate from AMA approved, Class A, PA program. Desires employment with G.P., F.P., or multispecialty clinic. Available 5-1-74. Contact: R. L. Eichelberger, 131 Summer Street, Malden, Mass. 02148 for Curriculum Vitae.



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# impotence

is driving them apart

## Android®-25 Tablets

**Android-10 Tablets    Android-5 Buccal**

Methyltestosterone N.F. —25, 10, 5 mg.

**For the treatment of impotence due to androgenic deficiency in the male.**

**DESCRIPTION:** Methyltestosterone is a 17 $\beta$ -Hydroxy-17-methyl-4-androst-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** in male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to endro- deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypo- edism. Cholestatic hepatitis with jaundice and altered function tests, such as increased BSP retention and SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in function tests, drug should be discontinued. **PRE- cautions:** Prolonged dosage of androgen may result in fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of cli-

mecleric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be dis-

continued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250.

# How strong must a tranquilizer be for severe anxiety?

## As strong as Librium® 25 mg (chlordiazepoxide HCl)



The achievement of desired therapeutic results is often a function of the dosage *strength* as well as the drug's intrinsic action. Thus, when anxiety is *severe*, the 25-mg strength of Librium frequently provides the necessary antianxiety action with a minimum of unwanted adverse reactions. Librium 25 mg is a convenient dosage form for the relief of severe, incapacitating anxiety, specifically formulated to supplement your counsel and reassurance.

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For over 13 years, Librium has been recognized for its excellent benefits-to-risks ratio, an asset in the *higher* dosage ranges as in more common clinical applications. Thus, the frequency of dosage with Librium 25 mg can be flexibly adjusted to the needs and response of the individual patient, up to 100 mg daily if required. Total daily dosage for the elderly and debilitated should not exceed 20 mg. When severe anxiety has been reduced, Librium dosage should be correspondingly reduced or discontinued entirely.



basic support  
in severe anxiety  
**Librium® 25 mg**  
(chlordiazepoxide HCl)  
1 capsule t.i.d./q.i.d.



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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.









